

# Application for a §1915 (c) HCBS Waiver

## HCBS Waiver Application Version 3.3

### Submitted by:

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

**Submission Date:**

**CMS Receipt Date** (*CMS Use*)

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

### Brief Description:

A request to renew 0175.90.R3 Mental Retardation Waiver Program and rename the waiver as the New Options Waiver (NOW).

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Effective Date	October 1, 2007

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

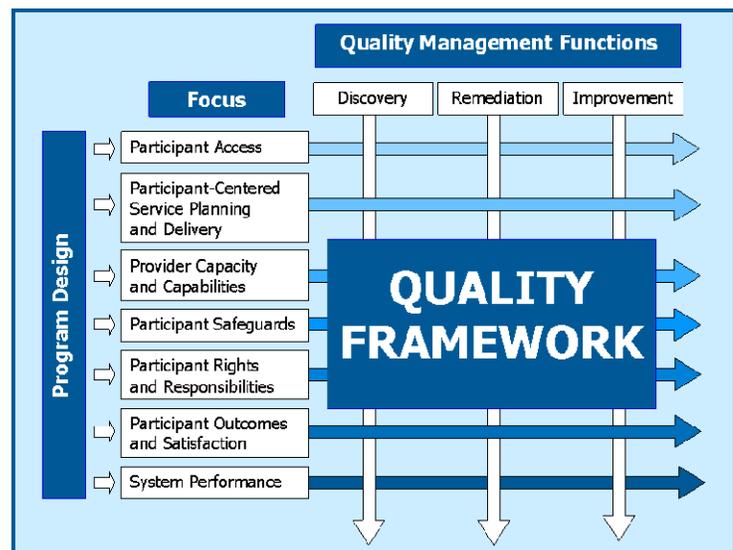
The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other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

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

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

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

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



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# 1. Request Information

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

B. Waiver Title (optional):

C. Type of Request (select only one):

<input type="radio"/>	<b>New Waiver (3 Years)</b>	CMS-Assigned Waiver Number (CMS Use):	
<input type="radio"/>	<b>New Waiver (3 Years) to Replace Waiver #</b>		
	CMS-Assigned Waiver Number (CMS Use):		
	<i>Attachment #1 contains the transition plan to the new waiver.</i>		
<input checked="" type="radio"/>	<b>Renewal (3 Years) of Waiver #</b>	#0175.90.R3	
	<b>Amendment to Waiver #</b>		

D. Type of Waiver (select only one):

<input type="radio"/>	<b>Model Waiver.</b> In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
<input checked="" type="checkbox"/>	<b>Regular Waiver</b> , as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date:

E.2 Approved Effective Date (CMS Use):

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

<input type="checkbox"/>	<b>Hospital</b> (select applicable level of care)
<input type="radio"/>	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:
	<input type="text"/>
<input type="radio"/>	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
<input type="checkbox"/>	<b>Nursing Facility</b> (select applicable level of care)
<input type="radio"/>	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:
	<input type="text"/>
<input type="radio"/>	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
<input checked="" type="checkbox"/>	<b>Intermediate Care Facility for the Mentally Retarded (ICF/MR)</b> (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:
	<input type="text"/>

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	Not applicable.
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**G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities (*check the applicable authority or authorities*):

<input type="checkbox"/>	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I		
<input type="checkbox"/>	Waiver(s) authorized under §1915(b) of the Act. <i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i>		
	Specify the §1915(b) authorities under which this program operates ( <i>check each that applies</i> ):		
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input type="checkbox"/>	§1915(b)(3) (employ cost savings to furnish additional services)
<input type="checkbox"/>	§1915(b)(2) (central broker)	<input type="checkbox"/>	§1915(b)(4) (selective contracting/limit number of providers)
<input type="checkbox"/>	A program authorized under §1115 of the Act. <i>Specify the program:</i>		
<input checked="" type="checkbox"/>	Not applicable		

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## 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 New Options Waiver (NOW) Program represents Georgia's commitment to continual improvement of home and community-based services for persons with mental retardation/developmental disabilities (MR/DD). Individuals eligible for NOW services live with family members or in their own home. NOW provides services for individuals with less intense and urgent needs than out-of-home residential treatment or extensive waiver supports to live safely in the community. The NOW Program includes safeguards for participants whose intensity of needs change post-entrance to the waiver. Individuals to be served in the NOW Program include current participants and additional participants receiving services due to recent funding increases by the Georgia General Assembly. The NOW Program uses a participant-centered assessment process to determine the support needs of participants and as the foundation for the development of the Individual Service Plan and the individual budget. The individual budget process is designed to increase flexibility in service delivery to meet exact individual need, enhance the predictability and consistent utilization management of the waiver funds, and support participant direction. Supports for community connection building and participant direction are essential components of the NOW Program. NOW includes services that provide these key supports to participants and their families.

**Purpose.** The purpose of NOW is to offer services and supports that enable individuals to remain living in their own or family home and participate in community life. To this end, NOW implements individualized budgeting, enhanced flexibility in service delivery, and increased opportunities for participant direction and community connection building.

**Goals.** NOW Program goals are to: (1) avoid the need for more intensive services; (2) increase independence and quality of life of individuals with MR/DD; (3) increase the flexibility of service planning and delivery to meet exact individual need; (4) provide the opportunity for all participants to elect to direct their services to the extent that they choose; and (5) ensure the health, safety and welfare of NOW participants.

**Objectives.** NOW Program objectives are to: (1) transition 100 percent of NOW participants to an individual budget by the end of the first year; (2) offer the opportunity for participant direction to 100 percent of NOW participants by the end of the first year; (3) afford NOW participants increased opportunities for community membership and supported employment at community work sites where persons without disabilities are employed; and, (4) increase access of NOW participants to community connections during evenings and weekends.

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

**Service Delivery Methods.** NOW provides individuals with MR/DD and their families the opportunity for enhanced freedom, choice, control, and responsibility over services received through the statewide

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availability of participant-directed service delivery. NOW participants may also opt for traditional service delivery.

**Quality Management.** The Quality Management Strategy includes tracking the effectiveness of these supports and all other NOW services in achieving the desired outcomes for participants. This Quality Management Strategy additionally includes discovery and monitoring processes to determine whether the waiver operates in accordance with the program's design, to assure the health and welfare of participants, and to identify opportunities for improvement.

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### 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*):

<input checked="" type="checkbox"/>	The waiver provides for participant direction of services. <i>Appendix E is required.</i>
<input type="checkbox"/>	Not applicable. The waiver does not provide for participant direction of services. <i>Appendix E is not completed.</i>

- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Management Strategy.** Appendix H contains the Quality Management Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

### 4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

	Yes
<input type="checkbox"/>	No
<input checked="" type="checkbox"/>	Not applicable

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

<input type="radio"/>	Yes ( <i>complete remainder of item</i> )
<input checked="" type="checkbox"/>	No

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

<input type="checkbox"/>	<b>Geographic Limitation.</b> A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. <i>Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:</i>
<input type="checkbox"/>	<b>Limited Implementation of Participant-Direction.</b> A waiver of statewideness is requested in order to make <i>participant direction of services</i> as specified in <b>Appendix E</b> 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. <i>Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:</i>

## 5. Assurances

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

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
  2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

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- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community-based waiver services.
- Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

## 6. Additional Requirements

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

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial

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

- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Management.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:

The Department of Community Health issued a public notice about the development of the waiver. The Department of Human Resources conducted fourteen forums throughout the State to obtain public input from September through December 2005. In addition, a stakeholder group met regularly to provide input on the development of the waiver from September through December 2005. This group was composed of individuals with developmental disabilities, family members, service providers, government officials, and advocacy group representatives. The State also held quarterly advocacy meetings where input on the waiver development was obtained. Finally, the State provided wide distribution of the draft waiver application for input and revision based on that

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input prior to submission.

- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

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

<b>First Name:</b>	Judy	OR	Marilyn
<b>Last Name</b>	Hagebak		Ellis
<b>Title:</b>	Director, Aging & Community Svcs		Program Specialist
<b>Agency:</b>	Department of Community Health, Division of Medical Assistance		
<b>Address 1:</b>	Two Peachtree Street, N.W.		
<b>Address 2:</b>			
<b>City</b>	Atlanta		
<b>State</b>	Georgia		
<b>Zip Code</b>	30303 - 3159		
<b>Telephone:</b>	(404) 657-5467		(404) 651-9174
<b>E-mail</b>	jhagebak@dch.ga.us		mellis@dch.ga.us
<b>Fax Number</b>	(404) 656-8366		

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

<b>First Name:</b>	Anne
<b>Last Name</b>	Tria
<b>Title:</b>	Waiver Coordinator
<b>Agency:</b>	Department of Human Resources, Division of Mental Health, Developmental Disabilities, and Addictive Diseases, Office of Developmental Disabilities
<b>Address 1:</b>	Two Peachtree Street, N.W. 22 <sup>nd</sup> Floor
<b>Address 2:</b>	
<b>City</b>	Atlanta
<b>State</b>	Georgia
<b>Zip Code</b>	30303-3159

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**Attachment #1:**

Specify the transition plan for the waiver:

**Availability of Current Waiver Services**

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

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

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

Respite is continued as a distinct service under NOW. No participants will lose respite services as a result of their transition to NOW.

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

The MRWP offers an array of services for individuals aimed at strengthening participants' natural support system in order for the individual to participate more fully and independently in his or her community. Services targeted for training and strengthening family and natural support members are available in NOW through the service, Natural Support Training. Direct services are continued through Community Living Support, Community Access and Respite Services. All behavioral consultation services currently offered are available under NOW's Behavioral Supports Consultation Services. These services are also available to participants that transfer to the COMP waiver.

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

Therapies currently offered and utilized as Natural Support Therapies are available under NOW's Adult Physical Therapy, Adult Occupational Therapy, and Adult Speech and Hearing Therapy Services.

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Nutritional Therapy Services has been offered under Natural Support Therapies but not utilized by participants and therefore is not included in the NOW.

Residential Training and Supervision (RTS) is a residential service that is currently available through the MRWP and CHSS waivers. RTS is targeted for individuals who require intense levels of support and live in small group residential settings or host home/life sharing arrangements. NOW is targeted for individuals who live with their families or in their own homes. RTS is not available through NOW. All individuals receiving RTS in the current waivers are transitioning to the COMP.

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

### **Transition Process**

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

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

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

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

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Appendix A: Waiver Administration and Operation

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

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

In the current waivers and, as will be true with the NOW Program, participants' re-authorization for services and Individual Service Plans are due on their respective birth dates. As participants' respective birth dates come up over the course of the NOW Program's first year of implementation, the processes described in this waiver application will be implemented for each individual participant. As participants' Individual Service Plans are developed on this schedule, participants' continuing need for the services they have been receiving as well as their need for new services made available through the NOW Program will be evaluated and addressed through their respective ISP process. If, due to a change in needs, individual members require an amendment in their ISP before the due date, a special ISP meeting is called and the indicated changes are made to the ISP at that time. In this circumstance, all NOW services will be considered and made available to the participant as the re-evaluation of his or her needs indicates.

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

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

<input type="radio"/>	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 ( <i>select one; do not complete Item A-2</i> ):
<input type="radio"/>	The Medical Assistance Unit ( <i>name of unit</i> ):
<input type="radio"/>	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit ( <i>name of division/unit</i> ):
<input checked="" type="checkbox"/>	The waiver is operated by Department of Human Resources, Division of Mental Health, Developmental Disabilities, and Addictive Diseases a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. <i>Complete item A-2.</i>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<input type="radio"/>	<b>Yes.</b> Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. <i>Complete Items A-5 and A-6.</i>
<input checked="" type="checkbox"/>	<b>No.</b> Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

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

<input type="checkbox"/>	<b>Local/Regional non-state public agencies</b> conduct waiver operational and administrative functions at the local or regional level. There is an <b>interagency agreement or memorandum of understanding</b> between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these agencies and complete items A-5 and A-6:</i>

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<input type="checkbox"/>	<b>Local/Regional non-governmental non-state entities</b> conduct waiver operational and administrative functions at the local or regional level. There is a <b>contract</b> 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). <i>Specify the nature of these entities and complete items A-5 and A-6:</i>
<input checked="" type="checkbox"/>	<b>Not applicable</b> – Local/regional non-state agencies do not perform waiver operational and administrative functions.

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

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

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

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assist individuals in waiver enrollment	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage waiver enrollment against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monitor waiver expenditures against approved levels	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct level of care evaluation activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Review participant service plans to ensure that waiver requirements are met	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform prior authorization of waiver services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct utilization management functions	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recruit providers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Execute the Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Determine waiver payment amounts or rates	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct training and technical assistance concerning waiver requirements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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# Appendix B: Participant Access and Eligibility

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

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

INCLUDED	TARGET GROUP/SUBGROUP	MINIMUM AGE	MAXIMUM AGE	
			MAXIMUM AGE LIMIT: THROUGH AGE –	NO MAXIMUM AGE LIMIT
<input type="radio"/>	<b>Aged or Disabled, or Both</b>			
<input type="checkbox"/>	Aged (age 65 and older)			<input type="checkbox"/>
<input type="checkbox"/>	Disabled (Physical) (under age 65)			
<input type="checkbox"/>	Disabled (Other) (under age 65)			
<b>Specific Aged/Disabled Subgroup</b>				
<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="radio"/>	<b>Mental Retardation or Developmental Disability, or Both</b>			
<input type="checkbox"/>	Autism			<input type="checkbox"/>
<input checked="" type="checkbox"/>	Developmental Disability	0		<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Mental Retardation	0		<input checked="" type="checkbox"/>
<input type="radio"/>	<b>Mental Illness</b>			
<input type="checkbox"/>	Mental Illness (age 18 and older)			<input type="checkbox"/>
<input type="checkbox"/>	Serious Emotional Disturbance (under age 18)			

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

The target group for the New Options Waiver Program includes individuals with a diagnosis of mental retardation and/or developmental disability (a diagnosis of developmental disability includes mental retardation or other closely related conditions such as cerebral palsy, epilepsy, autism, or neurological impairments which result in impairments of general intellectual functioning or adaptive behavior requiring treatment and services similar to those needed by persons with mental retardation). This target group is in accordance with Section 37-2-2 of the Official Code of Georgia Annotated. The NOW Program serves only individuals who live in their own or their family home.

- 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*):

<input checked="" type="checkbox"/>	Not applicable – There is no maximum age limit
<input type="radio"/>	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit ( <i>specify</i> ):

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## Appendix B-2: Individual Cost Limit

- a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*):

<input type="radio"/>	<b>No Cost Limit.</b> The State does not apply an individual cost limit. <i>Do not complete Item B-2-b or Item B-2-c.</i>
<input type="radio"/>	<b>Cost Limit in Excess of Institutional Costs.</b> 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. <i>Complete Items B-2-b and B-2-c.</i> The limit specified by the State is ( <i>select one</i> ):
<input type="radio"/>	<input type="text"/> %, a level higher than 100% of the institutional average
<input type="radio"/>	Other ( <i>specify</i> ): <input type="text"/>
<input type="radio"/>	<b>Institutional Cost Limit.</b> 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. <i>Complete Items B-2-b and B-2-c.</i>
<input checked="" type="checkbox"/>	<b>Cost Limit Lower Than Institutional Costs.</b> 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. <i>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.</i>
	The limit is based on an analysis of the historical costs for the services and supports included in the NOW Program as utilized by the defined population for this waiver program. The availability of other services and supports (e.g., family caregivers, Medicaid State Plan services, public education) for the defined NOW population and information on the utilization of these other services and supports contribute to the basis of this cost limit.
	The cost limit specified by the State is ( <i>select one</i> ):
<input checked="" type="checkbox"/>	The following dollar amount: \$ <input type="text" value="25,000"/>
	The dollar amount ( <i>select one</i> ):
<input type="radio"/>	Is adjusted each year that the waiver is in effect by applying the following formula: <input type="text"/>
<input checked="" type="checkbox"/>	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.
<input type="radio"/>	The following percentage that is less than 100% of the institutional average: <input type="text"/> %
<input type="radio"/>	Other – <i>Specify</i> : <input type="text"/>

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

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

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

<input checked="" type="checkbox"/>	The participant is referred to another waiver that can accommodate the individual's needs.
<input checked="" type="checkbox"/>	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized: The Support Coordinator may call an ISP review meeting in the event of an increased need for service by a waiver participant. If the interdisciplinary team review determines a need for increased intensity of services, the Intake & Evaluation Manager or designee may approve a time-limited increase in intensity of services. If it is determined that a waiver participant has an extended need for an increased intensity of services, the individual may be re-assessed and moved to a higher NOW allocation or be referred to the Comprehensive Supports Waiver Program.
<input type="checkbox"/>	Other safeguard(s) ( <i>specify</i> ):  

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## Appendix B-3: Number of Individuals Served

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

<b>Table: B-3-a</b>	
Waiver Year	Unduplicated Number of Participants
Year 1	7793
Year 2	7793
Year 3	7793
Year 4	7793
Year 5	7793

- 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)*:

<input type="radio"/>	The State does not limit the number of participants that it serves at any point in time during a waiver year.
<input checked="" type="checkbox"/>	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:

<b>Table B-3-b</b>	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	7091
Year 2	7091
Year 3	7091
Year 4	7091
Year 5	7091

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

<input checked="" type="checkbox"/>	<b>Not applicable.</b> The state does not reserve capacity.		
<input type="checkbox"/>	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:		
	The capacity that the State reserves in each waiver year is specified in the following table:		
	<b>Table B-3-c</b>		
		Purpose:	Purpose:
	Waiver Year	Capacity Reserved	Capacity Reserved
	Year 1		
	Year 2		
	Year 3		

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

<input checked="" type="checkbox"/>	The waiver is not subject to a phase-in or a phase-out schedule.
<input type="checkbox"/>	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an <i>intra-year</i> limitation on the number of participants who are served in the waiver.

- e. **Allocation of Waiver Capacity.** *Select one:*

<input checked="" type="checkbox"/>	Waiver capacity is allocated/managed on a statewide basis.
<input type="checkbox"/>	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:

<p>Individuals make application for the MR/DD waivers by completing a standardized application and submitting this to the Intake and Evaluation Office (I&amp;E) in their area. I&amp;E services are available statewide. A face-to-face screening is completed within 14 business days after receipt of the application. The intake screening process is intended to be the preliminary determination of an individual's eligibility for services based on the eligibility criteria. A written notification of</p>
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determination is sent to each applicant within 21 business days from the date stamped received on the application. Determinations include either presumed eligibility or ineligibility. Appeal processes are given at the time of intake and are reiterated in the eligibility letter received by each applicant.

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

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

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

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

Priority conditions for the Short Term Planning List are:

1. Consumer lost placement because of abandonment by caretaker.
2. Consumer is in immediate danger of losing home/care supports because of terminally ill caretaker.
3. Current placement is imminently harmful to consumer or consumer becomes a danger to others.
4. Consumer is gravely disabled and needs intensive supervision and care and parents/guardians

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are elderly or incapacitated.

5. Consumer is in need of more restrictive/intensive care after lesser care placement has failed.
6. Consumer/family needs can best be served in a community placement instead of the more restrictive, institutional environment.

Priority conditions for the Long Term Planning List are:

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

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

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

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

<input checked="" type="checkbox"/>	§1634 State
<input type="checkbox"/>	SSI Criteria State
<input type="checkbox"/>	209(b) State

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

<b><i>Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)</i></b>	
<input type="checkbox"/>	Low income families with children as provided in §1931 of the Act
<input checked="" type="checkbox"/>	SSI recipients
<input type="checkbox"/>	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
<input type="checkbox"/>	Optional State supplement recipients
<input type="checkbox"/>	Optional categorically needy aged and/or disabled individuals who have income at: ( <i>select one</i> )
<input type="checkbox"/>	100% of the Federal poverty level (FPL)
<input type="checkbox"/>	% of FPL, which is lower than 100% of FPL
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
<input type="checkbox"/>	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)
<input type="checkbox"/>	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)
<input type="checkbox"/>	Medically needy
<input type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify:</i>
<b><i>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</i></b>	
<input type="checkbox"/>	<b>No.</b> The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
<input checked="" type="checkbox"/>	<b>Yes.</b> The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. <i>Select one and complete Appendix B-5.</i>
<input type="checkbox"/>	All individuals in the special home and community-based waiver group under 42 CFR §435.217

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<input checked="" type="checkbox"/>	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 ( <i>check each that applies</i> ):		
<input checked="" type="checkbox"/>	A special income level equal to (select one):		
<input checked="" type="checkbox"/>	300% of the SSI Federal Benefit Rate (FBR)		
<input type="checkbox"/>	%	of FBR, which is lower than 300% (42 CFR §435.236)	
<input type="checkbox"/>	\$	which is lower than 300%	
<input type="checkbox"/>	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)		
<input type="checkbox"/>	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)		
<input type="checkbox"/>	Medically needy without spend down in 209(b) States (42 CFR §435.330)		
<input type="checkbox"/>	Aged and disabled individuals who have income at: ( <i>select one</i> )		
<input type="checkbox"/>	<input type="checkbox"/>	100% of FPL	
<input type="checkbox"/>	%	of FPL, which is lower than 100%	
<input type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify</i> :		

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## Appendix B-5: Post-Eligibility Treatment of Income

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

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

<input checked="" type="checkbox"/>	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 ( <i>select one</i> ):	
<input checked="" type="checkbox"/>	Use <i>spousal</i> post-eligibility rules under §1924 of the Act. <i>Complete Items B-5-b-2 (SSI State) or B-5-c-2 (209b State) and Item B-5-d.</i>	
<input type="checkbox"/>	Use <i>regular</i> post-eligibility rules under 42 CFR §435.726 (SSI State) ( <i>Complete Item B-5-b-1</i> ) or under §435.735 (209b State) ( <i>Complete Item B-5-c-1</i> ). <i>Do not complete Item B-5-d.</i>	
<input type="checkbox"/>	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. <i>Complete Item B-5-c-1 (SSI State) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.</i>	

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

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

<b>i. Allowance for the needs of the waiver participant</b> ( <i>select one</i> ):		
<input type="checkbox"/>	The following standard included under the State plan ( <i>select one</i> ):	
<input type="checkbox"/>	SSI standard	
<input type="checkbox"/>	Optional State supplement standard	
<input type="checkbox"/>	Medically needy income standard	
<input type="checkbox"/>	The special income level for institutionalized persons ( <i>select one</i> ):	
<input type="checkbox"/>		300% of the SSI Federal Benefit Rate (FBR)
<input type="checkbox"/>	%	of the FBR, which is less than 300%
<input type="checkbox"/>	\$	which is less than 300%.
<input type="checkbox"/>	%	of the Federal poverty level
<input type="checkbox"/>	Other (specify):	
<input type="checkbox"/>		

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<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:		
<b>ii. Allowance for the spouse only (select one):</b>			
<input type="radio"/>	SSI standard		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Not applicable (see instructions)		
<b>iii. Allowance for the family (select one):</b>			
<input type="radio"/>	AFDC need standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Other (specify):		
<input type="radio"/>	Not applicable (see instructions)		
<b>iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:</b>			
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. <i>Select one:</i>			
<input type="radio"/>	The State does not establish reasonable limits.		
<input type="radio"/>	The State establishes the following reasonable limits (specify):		

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

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**b-2. Regular Post-Eligibility Treatment of Income: SSI State.** The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

<b>i. Allowance for the needs of the waiver participant</b> ( <i>select one</i> ):			
<input checked="" type="checkbox"/>	The following standard included under the State plan ( <i>select one</i> )		
<input type="checkbox"/>	<input type="checkbox"/>	SSI standard	
<input type="checkbox"/>	<input type="checkbox"/>	Optional State supplement standard	
<input type="checkbox"/>	<input type="checkbox"/>	Medically needy income standard	
<input checked="" type="checkbox"/>	The special income level for institutionalized persons ( <i>select one</i> ):		
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	300% of the SSI Federal Benefit Rate (FBR)	
<input type="checkbox"/>	<input type="checkbox"/>	%	of the FBR, which is less than 300%
<input type="checkbox"/>	<input type="checkbox"/>	\$	which is less than 300%.
<input type="checkbox"/>	<input type="checkbox"/>	%	of the Federal poverty level
<input type="checkbox"/>	<input type="checkbox"/>	Other (specify):	
<input type="checkbox"/>	The following dollar amount: \$ If this amount changes, this item will be revised.		
<input type="checkbox"/>	The following formula is used to determine the needs allowance:		
<b>ii. Allowance for the spouse only</b> ( <i>select one</i> ):			
<input type="checkbox"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:		
Specify the amount of the allowance:			
<input type="checkbox"/>	<input type="checkbox"/>	SSI standard	
<input type="checkbox"/>	<input type="checkbox"/>	Optional State supplement standard	
<input type="checkbox"/>	<input type="checkbox"/>	Medically needy income standard	
<input type="checkbox"/>	<input type="checkbox"/>	The following dollar amount:	\$ If this amount changes, this item will be revised.
<input type="checkbox"/>	<input type="checkbox"/>	The amount is determined using the following formula:	
<input checked="" type="checkbox"/>	Not applicable		
<b>iii. Allowance for the family</b> ( <i>select one</i> ):			
<input checked="" type="checkbox"/>	AFDC need standard		
<input type="checkbox"/>	Medically needy income standard		
<input type="checkbox"/>	<input type="checkbox"/>	The following dollar amount:	\$ The amount specified cannot exceed the higher of the

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	need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.	
<input type="radio"/>	The amount is determined using the following formula: <table border="1" style="width: 100%; height: 20px;"> <tr><td> </td></tr> </table>	
<input type="radio"/>	Other (specify): <table border="1" style="width: 100%; height: 20px;"> <tr><td> </td></tr> </table>	
<input type="radio"/>	Not applicable (see instructions)	
<b>iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:</b>		
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. <i>Select one:</i>		
<input type="radio"/>	The State does not establish reasonable limits.	
<input checked="" type="radio"/>	The State establishes the following reasonable limits ( <i>specify</i> ): <table border="1" style="width: 100%; height: 20px;"> <tr><td> </td></tr> </table> The costs are allowed as income deductions up to specific dollar limits as to specific services and items. The dollar limits represent reasonable fees for services and items for this state as determined by Georgia medical and dental care industries.	

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

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

<b>i. Allowance for the personal needs of the waiver participant (<i>select one</i>):</b>		
<input type="radio"/>	SSI Standard	
<input type="radio"/>	Optional State Supplement standard	
<input type="radio"/>	Medically Needy Income Standard	
<input checked="" type="radio"/>	The special income level for institutionalized persons	
<input type="radio"/>	% of the Federal Poverty Level	
<input type="radio"/>	The following dollar amount: \$      If this amount changes, this item will be revised	
<input type="radio"/>	The following formula is used to determine the needs allowance: <table border="1" style="width: 100%; height: 20px;"> <tr><td> </td></tr> </table>	
<input type="radio"/>	Other ( <i>specify</i> ): <table border="1" style="width: 100%; height: 20px;"> <tr><td> </td></tr> </table>	
<b>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</b>		

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§435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. <i>Select one:</i>	
<input checked="" type="checkbox"/>	Allowance is the same
<input type="checkbox"/>	Allowance is different. Explanation of difference:
<b>iii.</b> Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:	
a. Health insurance premiums, deductibles and co-insurance charges.	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="checkbox"/>	The State does not establish reasonable limits.
<input checked="" type="checkbox"/>	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

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

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

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

<b>i.</b>	<b>Minimum number of services.</b>	The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is ( <i>insert number</i> ):
	1	
<b>ii.</b>	<b>Frequency of services.</b>	The State requires ( <i>select one</i> ):
	<input type="radio"/>	The provision of waiver services at least monthly
	<input checked="" type="checkbox"/>	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*):

<input type="radio"/>	Directly by the Medicaid agency
<input checked="" type="checkbox"/>	By the operating agency specified in Appendix A
<input type="radio"/>	By an entity under contract with the Medicaid agency. <i>Specify the entity:</i>
<input type="radio"/>	Other ( <i>specify</i> ):

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

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

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- d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State’s level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

**Initial Level of Care Criteria**

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

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

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

**Re-evaluations of LOC**

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

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

<input checked="" type="checkbox"/>	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
<input type="checkbox"/>	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

**Initial Evaluations**

Each person applying for waiver services does so through a public Mental Health, Developmental

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

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

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

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

**Re-evaluation of Level of Care**

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

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

The DMA-6 is received and reviewed by the Support Coordinator and forwarded to the LOC nurse for review and approval by the physician. Each LOC is in effect 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*):

<input type="radio"/>	Every three months
<input type="radio"/>	Every six months
<input checked="" type="checkbox"/>	Every twelve months
<input type="radio"/>	Other schedule ( <i>specify</i> ):

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

<input checked="" type="checkbox"/>	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
<input type="checkbox"/>	The qualifications are different. The qualifications of individuals who perform reevaluations are ( <i>specify</i> ):

**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*):

<p>MHDDAD operates an electronic database, the Waiver Information System (WIS), which has two (2) reports relating specifically to the timely management of Level of Care (LOC). The first report (LOC Expiration Dates) predicts all LOC that are 30, 60 and 90 days before expiration. This report allows sufficient and repeated (3 months) notification of the expiration of any and all LOCs. The report is reviewed monthly to identify each person in need of a re-evaluation and assists in the deployment of staff to complete the LOCs.</p> <p>The second report (Expired LOC) indicates any LOCs that were not completed prior to the expiration date. From this report, DHR tracks, monitors and reports the timeliness of LOC and ISP reassessments monthly. Any deficiencies are reviewed by DHR with appropriate action taken if deficiencies are noted and unexplained. DHR requires a corrective action plan when compliance is less than 90 percent. Each monthly report is forwarded to DCH to show current level of compliance for each region. DCH reviews each report and provides oversight as indicated from data in these reports.</p>
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**j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

<p>All LOC initial and re-evaluations are maintained (either electronically or in written form) for a minimum of five (5) years by the regional Intake and Evaluation teams. Copies are also provided to the appropriate Support Coordination agency and each provider of service. The official copy is maintained in MHDDAD regional offices.</p>
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## Appendix B-7: Freedom of Choice

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**DHR uses a range of resources that include:**

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

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

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

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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.

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# Appendix C: Participant Services

## Appendix C-1: Summary of Services Covered

- a. **Waiver Services Summary.** Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

<b>Statutory Services (check each that applies)</b>		
Service	Included	Alternate Service Title (if any)
Case Management	<input checked="" type="checkbox"/>	Support Coordination
Homemaker	<input type="checkbox"/>	
Home Health Aide	<input type="checkbox"/>	
Personal Care	<input type="checkbox"/>	
Adult Day Health	<input type="checkbox"/>	
Habilitation	<input type="checkbox"/>	
Residential Habilitation	<input checked="" type="checkbox"/>	Community Living Support
Day Habilitation	<input type="checkbox"/>	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	<input checked="" type="checkbox"/>	
Supported Employment	<input checked="" type="checkbox"/>	
Education	<input type="checkbox"/>	
Respite	<input checked="" type="checkbox"/>	
Day Treatment	<input type="checkbox"/>	
Partial Hospitalization	<input type="checkbox"/>	
Psychosocial Rehabilitation	<input type="checkbox"/>	
Clinic Services	<input type="checkbox"/>	
Live-in Caregiver (42 CFR §441.303(f)(8))	<input type="checkbox"/>	
<b>Other Services (select one)</b>		
<input type="radio"/>	Not applicable	
<input checked="" type="radio"/>	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute ( <i>list each service by title</i> ):	
a.	Community Access	
b.	Natural Support Training	

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c.	Individual Directed Goods and Services	
d.	Vehicle Adaptation	
e.	Environmental Accessibility Adaptation	
f.	Adult Physical Therapy Services	
g.	Adult Occupational Therapy Services	
h.	Adult Speech and Language Therapy Services	
i.	Behavioral Supports Consultation	
j.	Transportation	
k.	Adult Dental Services	
<b>Extended State Plan Services (select one)</b>		
<input type="radio"/>	Not applicable	
<input checked="" type="checkbox"/>	The following extended State plan services are provided (list each extended State plan service by service title):	
a.	Specialized Medical Equipment	
b.	Specialized Medical Supplies	
c.		
<b>Supports for Participant Direction (select one)</b>		
<input checked="" type="checkbox"/>	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.	
<input type="radio"/>	Not applicable	
Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	<input type="checkbox"/>	
Financial Management Services	<input checked="" type="checkbox"/>	Financial Support Services
Other Supports for Participant Direction (list each support by service title):		
a.	Community Guide	
b.		
c.		

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

<input type="checkbox"/>	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). <i>Complete item C-1-c.</i>
<input type="checkbox"/>	As an administrative activity. <i>Complete item C-1-c.</i>
<input type="checkbox"/>	Not applicable – Case management is not furnished as a distinct activity to waiver participants. <i>Do not complete Item C-1-c.</i>

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

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## Appendix C-2: General Service Specifications

- a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services-(*select one*):

**Yes.** Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

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

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

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

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

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

The DHR Office of Regulatory Services completes a review of each license annually. This annual review includes the review of the criminal record check on each employed individual. DHR also

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

**b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (*select one*):

<input type="radio"/>	<p><b>Yes.</b> The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):</p>
<input checked="" type="checkbox"/>	<b>No.</b> The State does not conduct abuse registry screening.

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

<input type="radio"/>	<p><b>No.</b> Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. <i>Do not complete Items C-2-c.i – c.iii.</i></p>
<input checked="" type="checkbox"/>	<p><b>Yes.</b> Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). <i>Complete Items C-2-c.i – c.iii.</i></p>

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

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Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Respite Facility	Respite	4
Personal Care Home	Respite	4

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

The NOW Program only uses residential facilities for respite and not as permanent living arrangements. The operating procedures for respite services facilities require these facilities to serve no more than two (2) to four (4) individuals and to emphasize a good home-like character that ties in well with the community. These facilities must be community-based and provide home environments, which include kitchens with cooking facilities, small dining areas, privacy, and easy access to resources and activities in the community. Exceptions to the facility capacity limit may be granted through the Office of Developmental Disabilities. In no instances will the exception be granted for a capacity that exceeds six (6). The good home-like character requirements apply to any facility granted an exception to the capacity limit.

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

Standard	Facility Type	Facility Type
	Respite	Personal Care Home
Admission policies	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

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

Not applicable

- d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and

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typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

<input checked="" type="checkbox"/>	<b>No.</b> The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
<input type="checkbox"/>	<b>Yes.</b> The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of <i>extraordinary care</i> by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.</i>

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

<input type="checkbox"/>	The State does not make payment to relatives/legal guardians for furnishing waiver services.
<input checked="" type="checkbox"/>	The State makes payment to relatives/legal guardians under <i>specific circumstances</i> and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.</i>
<p>State makes payment to parents of adults and other relatives (siblings, aunts, uncles, grandparents, cousins) aged 18 or older of children and adults approved under exceptional circumstances. Under no circumstances may a spouse of a participant, a parent/legal guardian of a child, a legal guardian of an adult, or a relative who serves as the representative for an individual in participant direction be approved to provide services. Exceptional circumstances include lack of qualified providers in remote areas, lack of a qualified provider who can furnish services at necessary times and places, presence of extraordinary and specialized skills or knowledge by approvable relatives in the provision of services and supports in the approved ISP, and/or clear demonstration of being the most cost effective and efficient means to provide the services. In the case of the request for a parent of an adult to provide waiver services, there must be a clear demonstration that the provision of the waiver services by the parent are in the best interests of the waiver participant. In addition, whenever the parent of an adult is approved to provide waiver services under exceptional circumstances, the support coordinator for the waiver participant assures at least an annual review of whether the continued provision of the waiver services by the parent is in the best interests of the adult waiver participant.</p> <p>Approvable relatives meeting the exceptional circumstances criteria may provide Community Access Services, Community Living Support Services, Respite and/or Transportation Services. DCH makes the final approval for payment of any traditional provider services furnished by relatives. Requests for payments of approvable relatives for participant-directed services are</p>	

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	made in writing to the MHDDAD Regional Office. Appeals of denials of these requests are sent to the MHDDAD Central Office. For traditional provider waiver services, the same monitoring procedures apply to ensure that payments are made only for services rendered as apply for the provision of these services by individuals other than approvable relatives. In these instances, the approvable relatives are employees of the DD service agency. For participant direction services, the Financial Support Services only pays for services specified in the Individual Service Plan, and support coordinators additionally monitor the provision of these services.
<input type="radio"/>	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.</i>
<input type="radio"/>	Other policy. <i>Specify:</i>

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

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

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## Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Support Coordination
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in current waiver. The service specifications have been modified.
<input checked="" type="checkbox"/>	Service is not included in the current waiver.
<b>Service Definition (Scope):</b>	
<p>Support Coordination services are a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for participants. A primary purpose of Support Coordination services is to maximize the health and safety of participants by addressing any needs of the individual, reviewing and addressing any identified risks. Support Coordination Services assist participants in coordinating all services, whether Medicaid reimbursed services or services provided by other funding sources. Support Coordinators are responsible for assembling both professionals and non-professionals who provide individualized supports and whose combined expertise and involvement ensures plans are individualized and person centered, and address all health and safety issues. The Support Coordinators assures that the individual gains access to needed medical, social, education, transportation, housing, nutritional, and other services identified in the Individual Service Plan; they encourage the use of various community resources through referral to appropriate traditional and non-traditional providers. The objective of Support Coordination is to protect the health and safety of an individual while ensuring access to needed waiver and other services.</p> <p>Support Coordinators assure the completion of the written Individual Service Plan (ISP) document and any revisions. Support Coordinators are also responsible for monitoring the implementation of the ISP and the health and welfare of participants. Monitoring includes direct observation, review of documents, and follow up to ensure that service plans have the intended effect and that approaches to address challenging behaviors, medical and health needs and skill acquisition are coordinated in their approach and anticipated outcome. Monitoring includes reviewing the quality and outcome of services. Support Coordinators are also responsible for the ongoing evaluation of the satisfaction of waiver participants and their families with the ISP. Support Coordinators assist waiver participants and their families or representatives in making informed decisions about the participant-direction option and assist those who opt for participant-direction with enrollment in this option.</p> <p>Participants who receive Community Living Support services in their own home must receive a minimum of one face-to face contact per month in the home where the supports are provided. Beyond this minimum requirement, the ISP team determines contacts based on the needs of the person and service mix. Individuals with higher needs, either medical or behavioral, and/or who have experienced problems must be monitored more frequently. Participants receive Support Coordination as determined by the ISP team and necessary based on their needs and service mix. This frequency is documented in each ISP but is no less frequently than one face to face contact per quarter.</p> <p>In a number of different situations, some flexibility in Support Coordination is required. For example, some participants or families may express a desire to assume more control in coordinating services for themselves or their family member. Individuals and their families may consider flexibility in Support Coordination if the following criteria are met:</p>	

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

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

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

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

Limit: one unit a month.

**Provider Specifications**

Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Case Management Agency
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	
Case Management Agency			Case Management Agency MHDDAD provider qualifications standards for	

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			<p>Support Coordination are:</p> <ol style="list-style-type: none"> <li>1) Must have available a sufficient number of Support Coordinators that meet the following State specific requirements for an individual who performs support coordination functions: at least 18 years of age, the QMRP educational and experiential standards of a minimum of a bachelor's degree in a human service field and at least one year's experience in serving persons with developmental disabilities, and completion of orientation training and annual mandatory additional DHR training in the area of Developmental Disabilities;</li> <li>2) Must have sufficient number of supervisory and quality assurance staff to provide training, support, and supervision of support coordinators, review support plans for quality, and provide oversight of any identified health and safety issues;</li> <li>3) Must have each Support Coordination office led by a manager who must serve as the primary liaison to the MHDDAD Regional Office;</li> <li>4) Must assign a designee for each business office as an emergency contact 24 hours a day, 7 days a week;</li> <li>5) Must adapt support coordination service to the unique cultural and socioeconomic characteristics of the MHDDAD region in which the agency is providing Support Coordination services;</li> <li>6) Assures regularly scheduled, outcome-oriented visits between Support Coordinators and waiver participants, at a minimum of one face-to-face visit per month if a waiver participant is supported in his/her own home or in other instances, at the frequency specified in the ISP;</li> </ol>
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			<p>7) Assures that visits between Support Coordinators and waiver participants focus on quality-inherent activities, such as open and respectful interaction, frequent and thoughtful communication, relationship building; rigorous tracking of the coordinated services that includes documentation of the effectiveness and efficiency of the delivery of services, follow up on any concerns of participant or family members, advocacy, increasing community participation, and assisting the participant to achieve desired outcomes;</p> <p>8) Must have agency policies and procedures that require Support Coordinators to inform the MHDDAD Regional Office of problems identified with provider agencies or with participant-directed services and to assist the waiver participant and the MHDDAD Regional Office in identifying alternative providers when necessary;</p> <p>9) Must provide Support Coordinators training as prescribed by DHR, Division of MHDDAD, with newly DHR developed training materials specific to the provision of support coordination services reviewed/approved by DCH;</p> <p>10) Must have established working relationships with local advocacy groups, experience advocating for individuals in the community, and preparing individuals for self advocacy;</p> <p>11) Must have at minimum five (5) years experience in providing case management services for individuals with MR/DD, and demonstrate success in supporting individuals in community inclusion and person centered planning;</p> <p>12) Must have experience and</p>
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			<p>demonstrated success with outcome based planning, and developing plans based on the individual's goals, choices and direction;</p> <p>13) Must have experience with measuring quality of services and satisfaction with services, ensuring that the services that are provided are consistent with quality measures and expectations of the individual;</p> <p>14) Meet all applicable MHDDAD standards for a public or private provider agency, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation);</p> <p>15) Meet all DCH and DHR enrollment criteria for a public or private provider agency.</p>
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Case Management Agency	DHR, Division of MHDDAD	Annual
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification			
Service Title:	Community Guide		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in current waiver. The service specifications have been modified.		
<input checked="" type="checkbox"/>	Service is not included in the current waiver.		
<b>Service Definition (Scope):</b>			
<p>Community Guide services are designed to empower participants to define and direct their own services and supports. These services are only for participants who opt for participant-direction. The participant determines the amount of Community Guide Services, if any, and the specific services that the Community Guide will provide. Community Guide Services include direct assistance to participants in brokering community resources and in meeting their participant-direction responsibilities. Community Guides provide information and assistance that help the participant in problem solving and decision making and in developing supportive community relationships and other resources that promote implementation of the Individual Service Plan. The exact direct assistance provided by Community Guides to assist the participant in meeting participant-direction responsibilities depends on the needs of the participant and includes assistance, if needed, with recruiting, hiring, training, managing, evaluating, and changing employees, scheduling and outlining the duties of employees, developing and managing the individual budget, and understanding provider qualifications, record keeping and other requirements. The specific Community Guide services for the participant are specified in the Individual Service Plan.</p> <p>Community Guide services do not duplicate Support Coordination services. Participants may elect to receive Community Guide services, and when elected, participants choose their Community Guide. The specific Community Guide services to be received by a waiver participant are specified in the Individual Service Plan. Community Guides cannot provide other direct waiver services, including Support Coordination, to any waiver participant. Community Guide agencies cannot provide Support Coordination services. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a Community Guide for that participant. Community Guide services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Unit of service: 15 minutes.			
Limit: 32 fifteen-minute units per day.			
224 units per year.			
\$2,000.32 annually.			
Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>
		Support Broker	Agency. List the types of agencies:
			Support Broker Agency
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
			Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Support Broker			MHDDAD support broker qualifications

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			<p>standards for Community Guides are:</p> <ol style="list-style-type: none"> <li>1. Is at least 18 years of age;</li> <li>2. Has the experience, training, education or skills necessary to meet the participant's needs 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;</li> <li>3. Agree to or provides required documentation of a criminal records check, prior to providing Community Guide services;</li> <li>4. Knowledgeable about resources in any local community in which the provider is a Community Guide;</li> <li>5. Demonstrated connections to the informal structures of any local community in which the provider is a Community Guide;</li> <li>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</li> <li>7. Attendance at all mandatory, MHDDAD training;</li> <li>8. Meet all applicable MHDDAD standards;</li> <li>9. Meet all DCH and DHR enrollment criteria.</li> </ol> <p>An individual serving as a waiver participant's representative to assist with self-direction responsibilities is not eligible to be a Community Guide.</p>
Support Broker Agency			<p>Support Broker Agency MHDDAD provider qualifications standards are:</p> <ol style="list-style-type: none"> <li>1. Must have available Community Guides that meet the standards established for individual support</li> </ol>

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			brokers; 2. Meet all applicable MHDDAD standards for a public or private provider agency, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD; 3. Meet all DCH and DHR enrollment criteria for a public or private provider agency.
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Support Broker	DHR, Division of MHDDAD	Annual
	Support Broker Agency	DHR, Division of MHDDAD	Annual
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification			
Service Title:	Community Access		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.		
<input checked="" type="checkbox"/>	Service is included in current waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the current waiver.		
<b>Service Definition (Scope):</b>			
<p>Community Access services are provided outside the participant's home or family home. Community Access services are designed to assist the participant in acquiring, retaining, or improving self-help, socialization, and adaptive skills required for active community participation and independent functioning outside the participant's home or family home. These services typically occur during the day but may also take place in the evenings and weekends. Community Access services are individually planned to meet the participant's needs and preferences for active community participation. Services include design of activities and environments for the participant to learn and/or use adaptive skills required for active community participation and independent functioning, assistance and/or training in self-help, socialization skills, and independent use of community resources, and other related assistance as indicated in the Individual Service Plan. Community Access Group services are provided to groups of participants, with a staff to participant ratio of one to two or more. The staff to participant ratio for Community Access Group services cannot exceed one (1) to ten (10). Community Access Individual services are provided to an individual participant, with a one-to-one staff to participant ratio.</p> <p>Community Access Services include transportation to and from activities and settings primarily utilized by people with disabilities. Transportation provided through Community Access Services is included in the cost of doing business and incorporated in the administrative overhead cost. Separate payment for transportation only occurs when the NOW's distinct Transportation Services are authorized.</p> <p>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.</p>			
<b>Specify applicable (if any) limits on the amount, frequency, or duration of this service:</b>			
Unit of service: 15 minutes.			
Community Access Group Limits: 24 fifteen-minute units per day. 504 fifteen-minute units per month. 5760 fifteen-minute units per year.			
Community Access Individual Limits: 40 fifteen-minute units per day. 1440 fifteen-minute units per year.			
Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
	Direct Support Professional		Accredited or Certified DD Service Agency
Specify whether the service may be provided by (check each that	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/> Relative/Legal Guardian Relative Only

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<i>applies):</i>			
Provider Qualifications ( <i>provide the following information for each type of provider</i> ):			
Provider Type:	License ( <i>specify</i> )	Certificate ( <i>specify</i> )	Other Standard ( <i>specify</i> )
Direct Support Professional			<p>Community Access MHDDAD individual provider qualifications standards are:</p> <ol style="list-style-type: none"> <li>1. Is at least 18 years of age or older;</li> <li>2. Has current CPR and Basic First Aid certifications;</li> <li>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;</li> <li>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;</li> <li>5. Agrees to or provides documentation of a criminal records check prior to the provision of Community Access services;</li> </ol> <p>Other standards are:  DCH and DHR enrollment criteria  DCH/DMA Policies and Procedures  MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR or an agreement with the Financial Support Services provider as follows:</p> <ol style="list-style-type: none"> <li>1. MHDDAD Provider Manual</li> <li>2. Applicable MHDDAD Standards</li> </ol>
Accredited or Certified DD Service Agency			DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures

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			MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows: <ul style="list-style-type: none"> <li>1. MHDDAD Provider Manual</li> <li>2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD</li> </ul>
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Direct Support Professional	DHR, Division of MHDDAD	Annual
	Accredited or Certified DD Service Agency	DHR, Division of MHDDAD	Annual
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification			
Service Title:	Prevocational Services		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.		
<input checked="" type="checkbox"/>	Service is included in current waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the current waiver.		
<b>Service Definition (Scope):</b>			
<p>Prevocational Services are services that prepare a participant for paid or unpaid employment. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Services are not job-task oriented, but instead, aimed at a generalized result. Services also include instruction in appropriate social interaction skills required in the workplace, and personal care/assistance as identified in the Individual Service Plan. Prevocational Services occur in facility-based settings or for mobile crews at sites outside the facility. These services are for the participant not expected to be able to join the general work force within one year as documented in the Individual Service Plan.</p> <p>Prevocational Services are specified in the participant's Individual Service Plan and are directed to habilitative rather than explicit employment objectives. If compensated, individuals are paid at less than 50 percent of the minimum wage and in accordance with the requirements of Part 525 of the Fair Labor Standards Act.</p> <p>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.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Unit of service: 15 minutes. Limit: 24 fifteen-minute units per day. 504 fifteen-minute units per month. 5760 fifteen-minute units per year.			
Provider Specifications			
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
			Accredited or Certified DD Service Agency
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Accredited or Certified DD Service Agency			DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as

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			<p>specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows:</p> <ol style="list-style-type: none"> <li>1. MHDDAD Provider Manual</li> <li>2. MHDDAD Standards, including accreditation by a national organization (CARE, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD</li> </ol>
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Accredited or Certified DD Service Agency	DHR, Division of MHDDAD	Annual
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification	
Service Title:	Supported Employment
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.
<input checked="" type="checkbox"/>	Service is included in current waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the current waiver.
<b>Service Definition (Scope):</b>	
<p>Supported Employment services are ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. The scope and intensity of Supported Employment supports may change over time, based on the needs of the participant. Supported Employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Supported Employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Supported Employment includes activities needed to sustain paid work by participants, including supervision and training. When Supported Employment services are provided in a work site where persons without disabilities are employed, payment is made only for adaptations, supervision, and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting. Supported Employment Group services are provided to groups of participants, with a staff to participant ratio of one to two or more. The staff to participant ratio for Supported Employment Group services cannot exceed one (1) to ten (10). Supported Employment Individual services are provided to an individual participant, with a one-to-one staff to participant ratio.</p> <p>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.</p> <p>Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).</p> <p>Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:</p> <ol style="list-style-type: none"> <li>1. Incentive payments made to an employer to encourage or subsidize the employer's participation in Supported Employment program;</li> <li>2. Payments that are passed through to users of Supported Employment programs; or</li> <li>3. Payments for training that is not directly related to an individual's Supported Employment program.</li> </ol> <p>Supported Employment services include transportation of two or more participants to community work sites. Transportation provided through Supported Employment services is included in the cost of doing business and incorporated in the administrative overhead cost. Separate payment for transportation only occurs when the NOW's distinct Transportation Services are authorized.</p> <p>Supported Employment are distinct from and do not occur at the same time of the same day as Community</p>	

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Access, Prevocational or Transportation services. An individual serving as a representative for a participant in self-directed services may not provide Supported Employment services. Supported Employment services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Unit of service: 15 minutes.			
Supported Employment Group Limits: 320 fifteen-minute units per month. 3840 fifteen-minute units per year.			
Supported Employment Individual Limits: 40 fifteen-minute units per day. 1440 fifteen-minute units per year.			
<b>Provider Specifications</b>			
Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
		Supported Employment Specialist	Accredited or Certified DD Service Agency
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/> Relative/Legal Guardian Relative Only
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Supported Employment Specialist			Supported Employment Specialist qualifications standards are: <ol style="list-style-type: none"> <li>1. Is at least 18 years of age or older;</li> <li>2. Has current CPR and Basic First Aid certifications;</li> <li>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;</li> <li>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;</li> <li>5. Agrees to or provides required documentation of a criminal records check prior to provision of Supported Employment services.</li> </ol> Other standards are:

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			<p>DCH and DHR enrollment criteria  DCH/DMA Policies and Procedures  MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR or an agreement with the Financial Support Services provider as follows:</p> <ol style="list-style-type: none"> <li>1. MHDDAD Provider Manual</li> <li>2. Applicable MHDDAD Standards</li> </ol>
Accredited or Certified DD Service Agency			<p>DCH and DHR enrollment criteria for a public or private agency  DCH/DMA Policies and Procedures  MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows:</p> <ol style="list-style-type: none"> <li>1. MHDDAD Provider Manual</li> <li>2. Applicable MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD</li> </ol> <p>Must have employees that meet the Support Employment Specialist qualifications.</p>
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Supported Employment Specialist	DHR, Division of MHDDAD	Annual
	Accredited or Certified DD Service Agency	DHR, Division of MHDDAD	Annual
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> (check each that applies):	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification	
Service Title:	Community Living Support
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.
<input checked="" type="checkbox"/>	Service is included in current waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the current waiver.
<b>Service Definition (Scope):</b>	
<p>Community Living Support services are designed to provide supports to participants who live in their own or family home. Community Living Support services are individually tailored supports that assist with the acquisition, retention, or improvement in skills related to a participant's continued residence in his or her own or family home. These supports include adaptive skill, social, and leisure skill development that assist the participant to reside in home living. Community Living Support services also include personal care and protective oversight and supervision. Community Living Support services include training in and personal care/assistance with activities of daily living (ADLs), such as bathing, dressing, toileting, and transferring, and with instrumental activities of daily living (IADLs), such as personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, and medication and money management. Community Living Support services may include medically related services, such as basic first aid, arranging and transporting participants to medical appointments, accompanying participants on medical appointments, documenting a participant's food and/or liquid intake or output, reminding participants to take medication, and assisting with self-administration of medication. Medically related services provided under Community Living Support services must be allowable by State law, rules, and regulations.</p> <p>Community Living Support services are provided only to participants who require in-home supports. Personal care/assistance may be a component part of Community Living Support services but may not comprise the entirety of the service. The amount of personal care/assistance is specific to the individual needs of the participant, as determined by the Supports Intensity Scale, the Health Risk Screening Tool, and other participant-centered assessment data. The individual amount of personal care/assistance provided the participant is specified in the Individual Service Plan. Community Living Support services may not be delivered to a person living in a home leased or owned by the service delivery agency except when the service is provided in a surrogate family setting. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Community Living Support services is specified in Appendix J. Payment is not made, directly or indirectly, to members of the individual's immediate family, except as provided in Appendix C-2. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed individual provider of Community Living Support services.</p> <p>A personal assistance retainer is a component of Community Living Support services. This retainer allows up to thirty (30) days of continued payment to personal caregivers under the waiver while a person is hospitalized or absent from his or her home.</p> <p>Transportation is included in the rate for Community Living Support services. Educational and related services needed by children for whom the Department of Education is responsible are excluded. Community Living Support services must not duplicate or be provided at the same period of the day as Community Access or Supported Employment services. The types and intensity of services provided are specific to the individual participant and detailed in his/her Individual Service Plan (ISP). An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed individual provider of Community Living Support services. Community Living Support services must be</p>	

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authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan (ISP) development and with any ISP revisions.

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

Unit of service: 15 minutes.  
 Limit: 6032 fifteen-minute units per year. Total amount of fifteen-minute units billed per day can not exceed \$138.09.

**Provider Specifications**

Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
	Direct Support Professional		Accredited or Certified DD Service Agency	

Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian Relative Only
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Provider Qualifications (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Accredited or Certified DD Service Agency	Private Home Care License (State of Georgia Rules and Regulations 290-4-54) if providing covered services as required by the Office of Regulatory Services		DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows: <ol style="list-style-type: none"> <li>MHDDAD Provider Manual</li> <li>MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD</li> </ol>
Direct Support Professional			Community Living Support MHDDAD individual provider qualifications standards are: <ol style="list-style-type: none"> <li>Is at least 18 years of age or older;</li> <li>Has current CPR and Basic First Aid certifications;</li> <li>Has the experience, training, education or skills necessary to meet the member's needs for Community Living Support</li> </ol>

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			<p>services as demonstrated by Direct Support Professional Certification or comparable training, education, or skills;</p> <p>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;</p> <p>5. Agrees to or provides required documentation of a criminal records check prior to provision of Community Living Support services.</p> <p>Other standards are:  DCH and DHR enrollment criteria  DCH/DMA Policies and Procedures  MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR or an agreement with the Financial Support Services provider as follows:</p> <ol style="list-style-type: none"> <li>MHDDAD Provider Manual</li> <li>Applicable MHDDAD Standards</li> </ol>
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Accredited or Certified DD Service Agency	DHR, Division of MHDDAD	Annual
	Direct Support Professional	DHR, Division of MHDDAD	Annual
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification	
Service Title:	Respite
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.
<input checked="" type="checkbox"/>	Service is included in current waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the current waiver.
<b>Service Definition (Scope):</b>	
<p>Respite Services provide brief periods of support or relief for caregivers or individuals with disabilities. Respite is provided in the following situations:</p> <ol style="list-style-type: none"> <li>(1) when families or the usual caretakers are in need of additional support or relief;</li> <li>(2) when the waiver participant needs relief or a break from the caretaker;</li> <li>(3) when a participant is experiencing a behavioral crisis and needs structured, short-term support;</li> <li>(4) when relief from care giving is necessitated by unavoidable circumstances, such as a family emergency.</li> </ol> <p>Respite may be provided in-home (provider delivers service in waiver participant's home) or out-of-home (waiver participant receives service outside of their home), and may include overnight. Respite Services are further defined by the designations, Maintenance Respite and Emergency/Crises Respite:</p> <p>Maintenance Respite provides brief periods of support or relief for caregivers or individuals with disabilities. Maintenance Respite is planned or scheduled respite and is provided: (1) when families or the usual caretakers are in need of additional support or relief; or (2) when the consumer needs relief or a break from the caretaker. Maintenance Respite may be provided in-home (provider delivers service in waiver participant's home) or out-of-home (waiver participant receives service outside of their home), and may include overnight.</p> <p>Emergency/Crises Respite is intended to be a short term service for a consumer experiencing a crisis (usually behavioral) and requires a period of structured support, or respite services are necessitated by unavoidable circumstances, such as a family emergency. Emergency/Crises Respite may be provided In-Home (provider delivers service in waiver participant's home) or Out-Of-Home (waiver participant receives service outside of their home), and may include overnight.</p> <p>A participant may receive both Respite services and Community Living Support services, but not simultaneously. No more than two to four members may receive Respite Services in a Respite Facility, unless granted an exception for up to six. A participant may not receive Respite Services in a facility providing residential services through the Comprehensive Supports Waiver. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed individual provider of Respite services. Respite services 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.</p>	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
<p>Unit of service: 15 minutes or overnight, dependent upon the needs of the waiver participant and as authorized.</p> <p>Limit: 1248 fifteen-minute units per year.  24 fifteen-minute units per day.  13 overnight units per year.</p> <p>Each overnight billing decreases annual fifteen-minute unit maximum by 24 units. \$3744 per year</p>	

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Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
		Direct Support Professional	Accredited or Certified DD Service Agency
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/> Relative/Legal Guardian Relative Only
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Accredited or Certified DD Service Agency	Private Home Care License (State of Georgia Rules and Regulations 290-4-54) if providing covered services in a participant's or family home as required by the Office of Regulatory Services		<p>DCH and DHR enrollment criteria for a public or private agency</p> <p>DCH/DMA Policies and Procedures</p> <p>MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows:</p> <ol style="list-style-type: none"> <li>MHDDAD Provider Manual</li> <li>MHDDAD Standards, including accreditation by a national organization (CARE, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD</li> </ol> <p>Must have Private Home Care Licensure if providing in-home respite services.</p> <p>Must meet DHR, MHDDAD standards for the provision of out-of-home respite, including requirements related to the service provision site.</p>
Direct Support Professional			<p>Respite MHDDAD individual provider qualifications standards are:</p> <ol style="list-style-type: none"> <li>Is at least 18 years of age or older;</li> <li>Has current CPR and Basic First Aid certifications;</li> <li>Has the experience, training, education or skills necessary to meet the member's needs for Respite services as demonstrated by Direct Support Professional Certification or comparable training, education, or skills;</li> </ol>

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			<p>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;</p> <p>5. Agrees to or provides required documentation of a criminal records check prior to provision of Respite services.</p> <p>Other standards are:  DCH and DHR enrollment criteria  DCH/DMA Policies and Procedures  MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR or an agreement with the Financial Support Services provider as follows:</p> <ol style="list-style-type: none"> <li>1. MHDDAD Provider Manual</li> <li>2. Applicable MHDDAD Standards</li> </ol> <p>Must meet DHR, MHDDAD standards for the provision of respite services, including requirements related to service provision site.</p>
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Accredited or Certified DD Service Agency	DHR, Division of MHDDAD	Annual
	Direct Support Professional	DHR Division of MHDDAD	Annual
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification			
Service Title:	Natural Support Training		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.		
<input checked="" type="checkbox"/>	Service is included in current waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the current waiver.		
<b>Service Definition (Scope):</b>			
<p>Natural Support Training (NST) Services provide training and education to individuals who provide unpaid support, training, companionship or supervision to participants. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a person served on the waiver. This service may not be provided in order to train paid caregivers. Training includes instruction about treatment regimens and other services included in the Individual Service Plan (ISP), use of equipment specified in the ISP, and includes updates as necessary to safely maintain the participant at home. NST Services include the costs of registration and training fees associated with formal instruction in areas relevant to participant needs identified in the ISP. NST Services do not include the costs of travel, meals and overnight lodging to attend a training event or conference. All training for individuals who provide unpaid support to the participant must be included in the participant's ISP.</p> <p>NST Services do not include services reimbursable by any other source. NST Services must not be duplicative of any education or training provided through Adult Physical Therapy Services, Adult Occupational Therapy Services, Adult Speech and Language Therapy Services, or Behavioral Supports Consultation Services. NST Services may not occur simultaneously or on the same day as Adult Physical Therapy Services, Adult Occupational Therapy Services, Adult Speech and Language Therapy Services, or Behavioral Supports Consultation Services. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed individual provider of Natural Support Training Services. NST 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.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Unit of service: 15-minutes. Limits: 86 units per year. \$1,787.08 per year			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>
		Developmental Disability Professional (DDP)	Agency. List the types of agencies: Accredited or Certified DD Service Agency
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
			Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Accredited or Certified DD			DCH and DHR enrollment criteria for a public or private agency

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Service Agency			<p>DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows:</p> <ol style="list-style-type: none"> <li>1. MHDDAD Provider Manual</li> <li>2. MHDDAD Standards, including accreditation by a national organization (CARE, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD</li> </ol> <p>Must have available employees that meet the MHDDAD standards for Developmental Disabilities Professional.</p>
Developmental Disability Professional (DDP)	Applicable professional license as required by Georgia Code Title 43-10-A-3, 43-26-3, 43-28-3, 43-33-3, 43-34-20, 43-39-1, 43-44-3.		<p>Meets definition of Developmental Disability Professional (DDP) in MHDDAD Standards</p> <p>Other standards are: DCH and DHR enrollment criteria DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR or an agreement with the Financial Support Services provider as follows:</p> <ol style="list-style-type: none"> <li>1. MHDDAD Provider Manual</li> <li>2. Applicable MHDDAD Standards</li> </ol>
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Accredited or Certified DD Service Agency	DHR Division of MHDDAD	Annual
	Developmental Disability Professional (DDP)	DHR Division of MHDDAD	Annual
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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**Service Specification**

Service Title: Individual Directed Goods and Services

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

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

**Service Definition (Scope):**

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

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

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

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

Limits: 20 units per year.  
\$1,500 annually.

**Provider Specifications**

<b>Provider Category(s)</b> <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Individual Vendor		Agency Vendor

<b>Specify whether the service may be provided by (check each that applies):</b>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
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Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individual Vendor	Applicable business license as required by the local, city, or county government in which the service is provided.		<p>Must be 18 years or older.</p> <p>Have a minimum of a high school diploma or GED Equivalent.</p> <p>Must have a documented minimum of two years of professional work experience in the area of purchasing OR related experience.</p> <p>OR</p> <p>Have an applicable business license for goods provided.</p> <p>Understands and agrees to comply with the participant-directed service and goods delivery requirements</p>
Agency Vendor	Applicable business license as required by the local, city, or county government in which the service is provided.		<p>Must have employees providing services that:</p> <p>Are 18 years or older;</p> <p>Have a minimum of a high school diploma or GED Equivalent; and</p> <p>Have a documented minimum of two years of professional work experience in the area of purchasing OR related experience</p> <p>OR</p> <p>Have an applicable business license for goods provided.</p> <p>Understands and agrees to comply with the participant-directed service and goods delivery requirements.</p>
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Individual Directed Vendor	DHR, Division of MHDDAD	Annual
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/> Provider managed

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Service Specification			
Service Title:	Financial Support Services		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input checked="" type="checkbox"/>	Service is included in current waiver. There is no change in service specifications.		
<input type="checkbox"/>	Service is included in current waiver. The service specifications have been modified.		
<input type="checkbox"/>	Service is not included in the current waiver.		
<b>Service Definition (Scope):</b>			
Financial Support Services are provided to assure that participant directed funds outlined in the Individual Service Plan are managed and distributed as intended. The Financial Support Services (FSS) provider receives and disburses funds for the payment of participant-directed services under an agreement with the Department of Community Health, the State Medicaid agency. The FSS-provider files claims through the Medicaid Management Information System for participant directed goods and services. Additionally, the FSS provider deducts all required federal, state and local taxes. The FSS provider also calculates and pays as appropriate, applicable unemployment insurance taxes and worker compensation on earned income. The FSS provider is responsible for maintaining separate accounts on each member's participant-directed service funds and producing expenditure reports as required by the Department of Community Health and the Department of Human Resources. When the participant is the employer of record, the FSS provider is the Internal Revenue Service approved Fiscal Employer Agent (FEA). The FSS provider conducts criminal background checks and age verification on service support workers. The FSS provider executes and holds Medicaid provider agreements through being deemed by the state to function as an Organized Health Care Delivery System or as authorized under a written agreement with the Department of Community Health, the State Medicaid agency. The FSS provider must not be enrolled to provide any other Medicaid services in Georgia. Financial Support Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Limit: One unit per month per member. \$75.00 per unit (rate per current negotiations). Actual rate may vary based on subsequent negotiations.			
Provider Specifications			
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>
			Agency. List the types of agencies: Fiscal Intermediary Agency
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
			Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Fiscal Intermediary Agency	Applicable Georgia business license as required by the local, city, or county government in which the services is	Must be approved by the IRS (under IRS Revenue Procedure 70-6) and meet requirements and functions as established by the IRS code, section 3504.	Must understand the laws and rules that regulate the expenditure of public resources; Utilize accounting systems that operate effectively on a large scale as well as track individual budgets; Adhere to the timelines for payment that meet the individual's needs within Department of Labor standards;

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	provided		<p>Develop, implement and maintain an effective payroll system that adheres all related tax obligations, both payment and reporting;</p> <p>Conduct and pay for criminal background checks (local and national) and age verification on service support workers;</p> <p>Generate service management, and statistical information and reports during each payroll cycle;</p> <p>Provide startup training and technical assistance to members, their representatives, and others as required;</p> <p>Process and maintain all unemployment records;</p> <p>Provide an electronic process for reporting and tracking timesheets and expense reports;</p> <p>Have at least two years of basic accounting and payroll experience;</p> <p>Must have a surety bond issued by a company authorized to do business in the State of Georgia in an amount equal to or greater than the monetary value of the members business accounts managed but not less than \$250,000;</p> <p>Must not be enrolled to provide any other Medicaid services in the State of Georgia;</p> <p>Must be approved by the IRS under procedure 70-6 and meet requirements and functions as established by IRS code, Section 3504.</p>
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Fiscal Intermediary Agency	Department of Community Health, Division of Medical Assistance	Annual
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification			
Service Title:	Specialized Medical Equipment		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.		
<input checked="" type="checkbox"/>	Service is included in current waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the current waiver.		
<b>Service Definition (Scope):</b>			
<p>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.</p> <p>The NOW 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. NOW 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 NOW does not cover items that have been denied through the DME and other programs for lack of medical necessity.</p> <p>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.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Limit: \$13,474.76 per member per lifetime. Annual maximum is \$5,200. Rates cannot exceed the established Medicaid rate, or in the absence of a Medicaid rate, the lower of three price quotes or the annual maximum.			
Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>
		Vendors and Dealers in Adaptive/Medical Equipment	Agency. List the types of agencies: Accredited or Certified DD Service Agency
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
		Relative/Legal Guardian	
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)

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Vendors and Dealers in Adaptive/Medical Equipment	Applicable Georgia business license as required by the local, city, or county government in which the services is provided.		DCH and DHR enrollment criteria DCH/DMA Policies and Procedures Have an applicable business license for goods provided.
Accredited or Certified DD Service Agency			DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows: <ul style="list-style-type: none"> <li>1. MHDDAD Provider Manual</li> <li>2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD</li> </ul>
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Vendors and Dealers in Adaptive/Medical Equipment	DHR, Division of MHDDAD	Annual
	Accredited or Certified DD Service Agency	DHR, Division of MHDDAD	Annual
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification				
Service Title:	Specialized Medical Supplies			
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>				
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.			
<input checked="" type="checkbox"/>	Service is included in current waiver. The service specifications have been modified.			
<input type="radio"/>	Service is not included in the current waiver.			
<b>Service Definition (Scope):</b>				
<p>Specialized Medical Supplies are various supplies, which enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. These supplies consist of food supplements, special clothing, diapers, bed wetting protective chucks, and other authorized supplies that are specified in the Individual Service Plan. Ancillary supplies necessary for the proper functioning of approved devices are also included in this service. If the waiver participant (or representative, if applicable) opts for participant direction, then these supplies may be purchased through participant-directed service delivery.</p> <p>The NOW 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. NOW 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 NOW does not cover items that have been denied through the DME and other programs for lack of medical necessity.</p> <p>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.</p>				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
Limit: \$1,734.48 annual maximum.				
Provider Specifications				
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Vendors and Dealers in Medical Supplies		Accredited or Certified DD Service Agency
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	
Vendors and Dealers in Medical Supplies	Applicable Georgia business license as required by local, city or county government in which the service is provided.		DCH and DHR enrollment criteria DCH/DMA Policies and Procedures Have an applicable business license for goods provided.	

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Accredited or Certified DD Service Agency			<p>DCH and DHR enrollment criteria for a public or private agency</p> <p>DCH/DMA Policies and Procedures</p> <p>MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows:</p> <ol style="list-style-type: none"> <li>1. MHDDAD Provider Manual</li> <li>2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD</li> </ol>
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Vendors and Dealers in Medical Supplies	DHR, Division of MHDDAD	Annual
	Accredited or Certified DD Service Agency	DHR, Division of MHDDAD	Annual
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification			
Service Title:	Vehicle Adaptation		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.		
<input checked="" type="checkbox"/>	Service is included in current waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the current waiver.		
<b>Service Definition (Scope):</b>			
<p>Vehicle Adaptation services enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. These adaptations are limited to a waiver participant's or his or her family's privately owned vehicle and include such things as a hydraulic lift, ramps, special seats and other interior modifications to allow for access into and out of the vehicle as well as safety while moving.</p> <p>The NOW Program is the payer of last resort for vehicle adaptations. The need for Vehicle Adaptation must be documented in the Individual Service Plan. Repair or replacement costs for vehicle adaptations of provider owned vehicles are not allowed. Vehicle adaptations will not be replaced in less than three years except in extenuating circumstances and authorized by the Division of Medical Assistance. Vehicle Adaptation must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
\$6,240.00 per member lifetime			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>
		Vehicle Adaptation Vendor	Agency. List the types of agencies: Accredited or Certified DD Service Agency
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
			Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Accredited or Certified DD Service Agency	Applicable Georgia business license as required by the local, city or county government in which the service is provided.		<p>DCH and DHR enrollment criteria for a public or private agency</p> <p>DCH/DMA Policies and Procedures</p> <p>MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows:</p> <ol style="list-style-type: none"> <li>MHDDAD Provider Manual</li> <li>MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on</li> </ol>

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			Accreditation) or certification by the DHR, Division of MHDDAD
Vehicle Adaptation Vendor	Applicable Georgia business license as required by the local, city, or county government in which the services are provided.		DCH and DHR enrollment criteria DCH/DMA Policies and Procedures Have an applicable business license for vehicle adaptation services provided.
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Accredited or Certified DD Service Agency	DHR, Division of MHDDAD	Annual
	Vehicle Adaptation Vendor	DHR, Division of MHDDAD	Annual
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification			
Service Title:	Environmental Accessibility Adaptation		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.		
<input checked="" type="checkbox"/>	Service is included in current waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the current waiver.		
<b>Service Definition (Scope):</b>			
<p>Environmental Accessibility Adaptation Services consist of adaptations which are designed to enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. Environmental Accessibility Adaptation Services consist of physical adaptations to the waiver participant's or family's home which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the waiver participant would require institutionalization. Such adaptations consist of the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). All services shall be provided in accordance with applicable state and local building codes.</p> <p>The NOW Program is the payer of last resort for environmental accessibility adaptations. Environmental Accessibility Adaptation Services will not be approved for modifications made to homes that are licensed by the State as Personal Care Homes or Community Living Arrangements. Environmental Accessibility Adaptation Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
\$10,400 per member per lifetime			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>
		Builders, Plumbers and Electricians	Agency. List the types of agencies: Accredited or Certified DD Service Agency
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
			Relative/Legal Guardian
<b>Provider Qualifications</b> <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Accredited or Certified DD Service Agency	Applicable Georgia license as required by OCGA 43-14-2 or 43-41-2		DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a

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			<p>Letter of Agreement between the Medicaid enrolled provider and DHR as follows:</p> <ol style="list-style-type: none"> <li>1. MHDDAD Provider Manual</li> <li>2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD</li> </ol> <p>Assures contractors for environmental accessibility adaptations hold applicable Georgia business license (OCGA Title 43).</p>
Builders, Plumbers and Electricians	Applicable business license as required by the local, city or county government in which the service is provided.		DCH and DHR enrollment criteria DCH/DMA Policies and Procedures
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Accredited or Certified DD Service Agency	DHR, Division of MHDDAD	Annual
	Builders, Plumbers and Electricians	DHR, Division of MHDDAD	Annual
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification					
Service Title:	Adult Physical Therapy Services				
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>					
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.				
<input type="radio"/>	Service is included in current waiver. The service specifications have been modified.				
<input checked="" type="checkbox"/>	Service is not included in the current waiver.				
<b>Service Definition (Scope):</b>					
<p>Adult Physical Therapy Services cover evaluation and therapeutic services that are not otherwise covered by Medicaid State Plan services. These services address the physical therapy needs of the adult participant that result from his or her developmental disability. Adult Physical Therapy Services promote gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities. Specific services include physical therapy evaluation, therapeutic procedures, therapeutic exercises to develop strength and endurance, and range of motion and flexibility, and participant/family education.</p> <p>Adult Physical Therapy Services are not available until the participant's 21<sup>st</sup> birthday. Adult Physical Therapy Services may be provided in or out of the participant's home. These services do not include the in-home therapeutic services for the treatment of an illness or injury that are covered in Home Health Services under the regular Medicaid State Plan. Adult Physical Therapy Services are provided by a licensed physical therapist and by order of a physician. Participants cannot receive Adult Physical Therapy Services if receiving Community Residential Alternatives through the Comprehensive Supports Waiver. Adult Physical Therapy Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.</p>					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
Limit: \$1,800.00 annual maximum for all adult therapy waiver services (including PT, OT, and SLT). The rate can not exceed the established Medicaid rates for the Children Intervention Services Program.					
Provider Specifications					
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:	
		Physical Therapist		Accredited or Certified DD Service Agency	
				Home Health Agency	
Specify whether the service may be provided by <i>(check each that applies):</i>		<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>					
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>		
Physical Therapist	Physical Therapist (OCGA 43-33-1)		DCH and DHR enrollment criteria DCH/DMA Policies and Procedures Physical Therapists providing Adult Physical Therapy Services must maintain applicable Georgia professional license.		
Accredited or Certified DD Service Agency			DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures		

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			<p>MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows:</p> <ol style="list-style-type: none"> <li>1. MHDDAD Provider Manual</li> <li>2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD</li> </ol> <p>Assures physical therapists providing Adult Physical Therapy Services hold applicable Georgia professional license (OCGA 43-33-1).</p>
Home Health Agency	Home Health Agency License (State of Georgia Rules and Regulations 290-5-38)		<p>DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows:</p> <ol style="list-style-type: none"> <li>1. MHDDAD Provider Manual</li> <li>2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD</li> </ol> <p>Assures physical therapists providing Adult Physical Therapy Services hold applicable Georgia professional license (OCGA 43-33-1).</p>
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Physical Therapist	DHR, MHDDAD	Annual
	Accredited or Certified DD Service Agency	DHR, MHDDAD	Annual
	Home Health Agency	DHR, MHDDAD	Annual
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> (check each that applies):	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification					
Service Title:	Adult Occupational Therapy Services				
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>					
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.				
<input type="radio"/>	Service is included in current waiver. The service specifications have been modified.				
<input checked="" type="checkbox"/>	Service is not included in the current waiver.				
Service Definition (Scope):					
<p>Adult Occupational Therapy Services cover evaluation and therapeutic services that are not otherwise covered by Medicaid State Plan services. These services address the occupational therapy needs of the adult participant that result from his or her developmental disability. Adult Occupational Therapy Services promote fine motor skills, coordination, sensory integration, and/or facilitate the use of adaptive equipment or other assistive technology. Specific services include occupational therapy evaluation, therapeutic activities to improve functional performance, sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, and participant/family education.</p> <p>Adult Occupational Therapy Services are not available until the participant's 21<sup>st</sup> birthday. Adult Occupational Therapy Services may be provided in or out of the participant's home. These services do not include the in-home therapeutic services for the treatment of an illness or injury that are covered in Home Health Services under the regular Medicaid State Plan. Adult Occupational Therapy Services are provided by a licensed occupational therapist and by order of a physician. Participants cannot receive Adult Occupational Therapy Services if receiving Community Residential Alternatives through the Comprehensive Supports Waiver. Adult Occupational Therapy Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.</p>					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
Limit: \$1,800.00 annual maximum for all adult therapy waiver services (including PT, OT, and SLT). The rate can not exceed the established Medicaid rates for the Children Intervention Services Program.					
Provider Specifications					
Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:	
		Occupational Therapist		Accredited or Certified DD Service Agency	
				Home Health Agency	
Specify whether the service may be provided by (check each that applies):		<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):					
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)		
Occupational Therapist	Occupational Therapist (OCGA 43-28-1)		DCH and DHR enrollment criteria DCH/DMA Policies and Procedures Occupational Therapists providing Adult Occupational Therapy Services must maintain applicable Georgia professional license.		
Accredited or Certified DD			DCH and DHR enrollment criteria for a public or private agency		

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Service Agency			<p>DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows:</p> <ol style="list-style-type: none"> <li>1. MHDDAD Provider Manual</li> <li>2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD</li> </ol> <p>Assures occupational therapists providing Adult Occupational Therapy Services hold applicable Georgia professional license (OCGA 43-28-1).</p>
Home Health Agency	Home Health Agency License (State of Georgia Rules and Regulations 290-5-38)		<p>DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows:</p> <ol style="list-style-type: none"> <li>1. MHDDAD Provider Manual</li> <li>2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD</li> </ol> <p>Assures occupational therapists providing Adult Occupational Therapy Services hold applicable Georgia professional license (OCGA 43-28-1).</p>
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Occupational Therapist	DHR, MHDDAD	Annual
	Accredited or Certified DD Service Agency	DHR, MHDDAD	Annual
	Home Health Agency	DHR, MHDDAD	Annual
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> (check each that applies):	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification			
Service Title:	Adult Speech and Language Therapy Services		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in current waiver. The service specifications have been modified.		
<input checked="" type="checkbox"/>	Service is not included in the current waiver.		
Service Definition (Scope):			
<p>Adult Speech and Language Therapy Services cover evaluation and therapeutic services that are not otherwise covered by Medicaid State Plan services. These services address the speech and language therapy needs of the adult participant that result from his or her developmental disability. Adult Speech and Language Therapy Services preserve abilities for independent function in communication, facilitate oral motor and swallowing functions, facilitate use of assistive technology, and/or prevent progressive disabilities. Specific services include speech and language therapy evaluation, individual treatment of speech, language, voice, communication, and/or auditory processing, therapeutic services for the use of speech-generating device, including programming and modification, and participant/family education.</p> <p>Adult Speech and Language Therapy Services are not available until the participant's 21<sup>st</sup> birthday. Adult Speech and Language Therapy Services may be provided in or out of the participant's home. These services do not include the in-home therapeutic services for the treatment of an illness or injury that are covered in Home Health Services under the regular Medicaid State Plan. Adult Speech and Language Therapy Services are provided by a licensed speech and language pathologist and by order of a physician. Participants cannot receive Adult Speech and Language Therapy Services if receiving Community Residential Alternatives through the Comprehensive Supports Waiver. Adult Speech and Language Therapy Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Limit: \$1,800.00 annual maximum for all adult therapy waiver services (including PT, OT, and SLT). The rate can not exceed the established Medicaid rates for the Children Intervention Services Program.			
Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>
		Speech and Language Pathologist	Agency. List the types of agencies:
			Accredited or Certified DD Service Agency
			Home Health Agency
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
			Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Speech and Language Pathologist	Speech and Language Pathologist (OCGA 43-44-1)		DCH and DHR enrollment criteria DCH/DMA Policies and Procedures Speech and Language Pathologists providing Adult Speech and Language Therapy Services must maintain applicable Georgia professional license.
Accredited or			DCH and DHR enrollment criteria for a

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Certified DD Service Agency			<p>public or private agency  DCH/DMA Policies and Procedures  MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows:</p> <ol style="list-style-type: none"> <li>1. MHDDAD Provider Manual</li> <li>2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD</li> </ol> <p>Assures Speech and Language Pathologists providing Adult Speech and Language Therapy Services hold applicable Georgia professional license (OCGA 43-28-1).</p>
Home Health Agency	Home Health Agency License (State of Georgia Rules and Regulations 290-5-38)		<p>DCH and DHR enrollment criteria for a public or private agency  DCH/DMA Policies and Procedures  MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows:</p> <ol style="list-style-type: none"> <li>1. MHDDAD Provider Manual</li> <li>2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD</li> </ol> <p>Assures Speech and Language Pathologists providing Adult Speech and Language Therapy Services hold applicable Georgia professional license (OCGA 43-28-1).</p>
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Speech and Language Pathologist	DHR, MHDDAD	Annual
	Accredited or Certified DD Service Agency	DHR, MHDDAD	Annual

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	Home Health Agency	DHR, MHDDAD	Annual
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification			
Service Title:	Behavioral Supports Consultation		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in current waiver. The service specifications have been modified.		
<input checked="" type="checkbox"/>	Service is not included in the current waiver.		
<b>Service Definition (Scope):</b>			
Behavioral Support Consultation services are those that assist the waiver participant with significant, intensive challenging behaviors that interfere with activities of daily living, social interaction, work or similar situations. These services provide for the development of Behavioral Supports plans for the acquisition or maintenance of appropriate behaviors for community living and behavioral intervention for the reduction of maladaptive behaviors. Intervention modalities described in plans must relate to the identified behavioral needs of the waiver participant, and specific criteria for remediation of the behavior must be established and specified in the plan.			
Behavioral Supports Consultation services are provided by appropriately qualified individuals with expertise in behavioral supports evaluation and services for people with developmental disabilities. Behavioral Supports Consultation services must not be duplicative of any family education or training provided through NST Services. Behavioral Supports Consultation services may not occur simultaneously or on the same day as NST Services. Behavioral Supports Consultation services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Unit of service is 15 minutes.			
Limits: 104 fifteen-minute units per year.			
\$2,450.24 annual maximum.			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input type="checkbox"/> Agency. List the types of agencies:
		Positive Behavioral Supports Specialist	
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
<b>Provider Qualifications</b> <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Positive Behavioral Supports Specialist	Psychologist (OCGA 43-39-1); Licensed Professional Counselor		DCH and DHR enrollment criteria DCH/DMA Policies and Procedures Meets to following Positive Behavioral Supports Specialist Standards: 1. Minimum of a Masters degree in psychology,

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

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Service Specification				
Service Title:	Transportation			
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>				
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.			
<input type="radio"/>	Service is included in current waiver. The service specifications have been modified.			
<input checked="" type="checkbox"/>	Service is not included in the current waiver.			
<b>Service Definition (Scope):</b>				
<p>Transportation Services enable waiver participants to gain access to waiver and other community services, activities, resources, and organizations typically utilized by the general population. These services do not include transit provided through Medicaid non-emergency transportation. Transportation services are only provided as independent waiver services when transportation is not otherwise available as an element of another waiver service. Whenever possible, family, neighbors, friends or community agencies, which can provide this service without charge, are to be utilized. Transportation services are not intended to replace available formal or informal transit options for participants. The need for Transportation services and the unavailability of other resources for transportation must be documented in the ISP.</p> <p>Transportation services are not available to transport an individual to school (through 12<sup>th</sup> grade). Transportation to and from school is the responsibility of the public school system or the waiver participant's family. Transportation services must not be available under the Medicaid State Plan, IDEA or the Rehabilitation Act. Transportation services exclude transportation to and from Community Access Services that entail activities and settings primarily utilized by people with disabilities. Transportation services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.</p>				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
Unit of service: encounter/one-way trip or commercial carrier/multipass.				
Limits: 203 units per year for encounter/one-way trip. \$2,797.34 annual maximum.				
Provider Specifications				
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Licensed Driver		Transportation Broker
				Accredited or Certified DD Service Agency
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian Relative Only
<b>Provider Qualifications</b> <i>(provide the following information for each type of provider):</i>				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	
Licensed Driver	Valid, Class C license as defined by the Georgia Department of Driver Services		Driver must be at least 18 years of age, hold a valid, Class C State of Georgia driver's license, and have no major traffic violations; Has current mandatory insurance; Agrees to or provides required documentation of criminal background	

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			<p>check.</p> <p>Has the training or skills necessary to meet the participant’s needs as demonstrated by documented prior experience or training on providing services to individuals with MR/DD and in addressing any disability-specific needs of the participant</p> <p>Other standards are:</p> <p>DCH and DHR enrollment criteria</p> <p>DCH/DMA Policies and Procedures</p> <p>MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR or an agreement with the Financial Support Services provider as follows:</p> <ol style="list-style-type: none"> <li>1. MHDDAD Provider Manual</li> <li>2. Applicable MHDDAD Standards</li> </ol>
Transportation Broker			<p>DCH and DHR enrollment criteria for a public or private agency</p> <p>DCH/DMA Policies and Procedures</p> <p>MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR or an agreement with the Financial Support Services provider as follows:</p> <ol style="list-style-type: none"> <li>1. MHDDAD Provider Manual</li> <li>2. Applicable MHDDAD Standards</li> </ol> <p>Must provide commercial carrier services to the community at large</p>
Accredited or Certified DD Service Agency			<p>DCH and DHR enrollment criteria for a public or private agency</p> <p>DCH/DMA Policies and Procedures</p> <p>MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows:</p> <ol style="list-style-type: none"> <li>1. MHDDAD Provider Manual</li> <li>2. MHDDAD Standards, including</li> </ol>

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			<p>accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD</p> <p>Must ensure that any driver is at least 18 years of age, holds a valid, Class C State of Georgia driver's license, have no major traffic violations, has current mandatory insurance, has a criminal background check, and has required training or prior experience.</p>
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Licensed Driver	DHR, Division of MHDDAD	Annual
	Transportation Broker	DHR, Division of MHDDAD	Annual
	Accredited or Certified DD Service Agency	DHR, Division of MHDDAD	Annual
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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Service Specification			
Service Title:	Adult Dental Services		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in current waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in current waiver. The service specifications have been modified.		
<input checked="" type="checkbox"/>	Service is not included in the current waiver.		
Service Definition (Scope):			
<p>Adult Dental Services cover dental treatments and procedures that are not otherwise covered by Medicaid State Plan services. Adult Dental Services include semiannual diagnostic and preventive services and a limited coverage of restorative treatment and periodontal procedures. These services strive to prevent or remedy dental problems that, if left untreated, could compromise a participant's health, by increasing the risk of infection or disease, or reducing food options, resulting in restrictive nutritional intake.</p> <p>Adult Dental Services are not available until the waiver participant's 21<sup>st</sup> 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.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Adult Dental Services do not exceed \$500 annual maximum. Rates cannot exceed established Medicaid rates.			
Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input type="checkbox"/>
		Dentist	Agency. List the types of agencies:
Specify whether the service may be provided by (check each that applies):		<input type="checkbox"/>	Legally Responsible Person
		<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Dentist	Dentist as required under OCGA Title 43-11-1		<p>The dentist must hold current, valid license to practice dentistry (OCGA Title 43).</p> <p>Adult Dental Services are provided personally by a licensed dentist or by a salaried dental hygienist under the dentist's direct supervision.</p> <p>Dentists providing Adult Dental Services through the direct supervision of dental hygienists ensure the dental hygienists hold current, valid licenses to practice their profession (OCGA Title 43-11-1).</p>

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Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Dentist	DHR, Division of MHDDAD	Annual
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

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

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

*When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.*

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

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that are statistically significant in explaining differences in service expenditures, and a prospective individual budget amount assignment algorithm was developed. The resulting algorithm exhibits a high correlation between historical funding authorizations and measured supports needs.

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

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

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

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

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

In the event of a major change in the participant's condition or in the unpaid supports available to a participant (e.g., the incapacity of a family caregiver), the support coordinator may call an ISP review meeting. If the interdisciplinary team review determines a need for increased intensity of

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	<p>services, the Intake &amp; Evaluation Manager or designee may approve a time-limited increase in intensity of services. If it is determined that a waiver participant has an extended need for an increased intensity of services, the individual may be re-assessed and moved to a higher NOW allocation. In the event that a participant is assessed as requiring a prospective individual budget amount that is in excess of the waiver’s individual cost limit (including the need for services in settings that are not available under the waiver), the participant will be offered enrollment in the Comprehensive Waiver Program and an interim ISP will be developed to assure continuity of services during the transition.</p>
<input type="checkbox"/>	<p><b>Budget Limits by Level of Support.</b> Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. <i>Furnish the information specified above.</i></p>
<input type="checkbox"/>	<p><b>Other Type of Limit.</b> The State employs another type of limit. <i>Describe the limit and furnish the information specified above.</i></p>
<input type="checkbox"/>	<p><b>Not applicable.</b> The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.</p>

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# Appendix D: Participant-Centered Planning and Service Delivery

<b>State Participant-Centered Service Plan Title:</b>	Individual Service Plan
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**a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*check each that applies*):

<input type="checkbox"/>	Registered nurse, licensed to practice in the State
<input type="checkbox"/>	Licensed practical or vocational nurse, acting within the scope of practice under State law
<input type="checkbox"/>	Licensed physician (M.D. or D.O)
<input type="checkbox"/>	Case Manager (qualifications specified in Appendix C-3)
<input type="checkbox"/>	Case Manager (qualifications not specified in Appendix C-3). <i>Specify qualifications:</i>
<input type="checkbox"/>	Social Worker. <i>Specify qualifications:</i>
<input checked="" type="checkbox"/>	<p><b>Other (<i>specify the individuals and their qualifications</i>):</b></p> <p>The Support Coordinator develops the ISP in partnership with the Intake and Evaluation Team when a person enters a MR/DD waiver. Each team must include a registered nurse, a social worker, and a psychologist or behavioral specialist. Other disciplines that provide services to the applicant must also be a part of the I&amp;E Team (e.g., Occupational Therapist, Speech Therapist, and/or and Physical Therapist). Each professional must remain licensed in his or her respective professions. Each I&amp;E team member must also be a Qualified Mental Retardation Professional. A QMRP has at least a Bachelor’s degree in social work, psychology, or closely related field with one year of experience with persons with mental retardation/developmental disabilities.</p> <p>After the initial ISP, the support coordinator is responsible for service plan development. Support Coordinators work for agencies enrolled as Medicaid providers of Support Coordination services. A Qualified Mental Retardation Professional (QMRP) must provide the Support Coordination services. A QMRP meets the qualifications defined above.</p>

**b. Service Plan Development Safeguards. *Select one:***

<input checked="" type="checkbox"/>	Entities and/or individuals that have responsibility for service plan development <i>may not provide</i> other direct waiver services to the participant.
<input type="checkbox"/>	<p>Entities and/or individuals that have responsibility for service plan development <i>may provide</i> other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. <i>Specify:</i></p>

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- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant’s authority to determine who is included in the process.

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

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

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant’s needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

DHR has recently revised the ISP process to include the use of a “Person Centered Process” and format. This format supports each person and his or her family (as appropriate) to identify preferences and goals for each service provided for inclusion in his or her plan. Training in this “Person Centered” format has been completed across the state to providers, support coordinators, and team members. To ensure waiver participants have choice about how needs are met, the ISP process requires the completion of a section of the ISP by the individual or his or her family prior to the written plan being developed. This section is the foundation of the ISP as it includes each person’s hopes, dreams, and desires as well as what works/does not work for each person. It is the Support Coordinator’s responsibility to ensure that pre-meeting discussions about the participants’ hopes, dreams, and desires occur. Prior to the formal Individual Service Plan meeting, the Support Coordinator meets with the participant and others as requested by the

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participant such as family, friends, co-workers, etc. to discuss the upcoming planning process. In this visit, the Support Coordinator assists in the completion of page 4 of the Individual Services Plan (ISP) format.

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

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

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

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

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

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

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

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

There is a line in this section for the waiver participant to sign and also a line for a parent or guardian to sign as appropriate. In the event that the participant, his family or guardian does not participate in the formal ISP meeting, the reason for the absence must be documented in this same section. It is assumed that the absence of a participant and others of his/her choosing at the ISP meeting will be a very rare event. Documentation of such absences is reviewed and evaluated as a part of the routine ISP Quality Assurance

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process.

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

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

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

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

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

**Risks/Protection Section of the Individual Service Plan**

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

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protocols are developed to support identified risks.

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

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

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

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

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

#### **Assessment of Other Concerns/Problems**

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

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

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

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

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

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

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

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

During reviews, the participants’ care plans and service records are reviewed for appropriateness of service, to ensure services are provided in accordance with the ISP and prior authorization, and adequacy of documentation of services that have billed to Medicaid. Failure of the provider to

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

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. *Specify the minimum schedule for the review and update of the service plan:*

<input type="radio"/>	Every three months or more frequently when necessary
<input type="radio"/>	Every six months or more frequently when necessary
<input checked="" type="checkbox"/>	Every twelve months or more frequently when necessary
<input type="radio"/>	Other schedule ( <i>specify</i> ):

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following (*check each that applies*):

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

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## Appendix D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

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

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

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

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

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

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

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HRST, the nursing assessment, and physician reports. The format and the HRST thus identify health and risk factors that Support Coordinators then monitor.

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

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

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

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

**b. Monitoring Safeguards. Select one:**

<input checked="" type="checkbox"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may not provide</i> other direct waiver services to the participant.
<input type="checkbox"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may provide</i> other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. <i>Specify:</i>

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# Appendix E: Participant Direction of Services

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

**Applicability** (select one):

<input checked="" type="checkbox"/>	<b>Yes.</b> This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
<input type="checkbox"/>	<b>No.</b> This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction. Indicate whether Independence Plus designation is requested (select one):*

<input checked="" type="checkbox"/>	<b>Yes.</b> The State requests that this waiver be considered for Independence Plus designation.
<input type="checkbox"/>	<b>No.</b> Independence Plus designation is not requested.

## Appendix E-1: Overview

**a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver’s approach to participant direction.

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

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

All NOW participants receive an individual waiver allocation, as described in Appendix C-4. The individualized budgeting process in the NOW Program ties waiver allocations to direct assessments of the support needs of participants. All participants in the NOW Program are assessed with the SIS

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

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

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

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

Support Coordinators are responsible for assessing the participant or representative who request participant direction to determine the ability to assume the responsibilities of participant direction, consisting of, where applicable, being the employer of support workers. Support Coordinators also inform a participant that a family member/representative may assist him or her with participant direction. The Support Coordinator provides the participant or the representative who opts for participant direction with: (1) the process for changing the ISP and the participant-directed budget; (2) the grievance process; (3) the requirement of freedom of choice of providers; (4) individual rights; and (5) the reassessment and review schedules. In addition, Support Coordinators assist the participant or representative with: (1) the development of risk management agreements; (2) development of the

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individual emergency back-up plan; (3) recognizing and reporting critical events; and (4) accessing independent advocacy, to assist in grievances and problem resolution when necessary. Support Coordinators also arrange for Community Guide services to assist with participant direction responsibilities, including participant-directed budget development, training to be effective employers, and brokering of available community resources. Support Coordinators actively monitor participant-directed services, in conjunction with the employer supervision provided by the participant or representative, in order to ensure quality of care and to protect the health and safety of the participant.

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

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

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

**b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one:*

<input type="radio"/>	<b>Participant – Employer Authority.</b> As specified in <i>Appendix E-2, Item a</i> , the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
<input type="radio"/>	<b>Participant – Budget Authority.</b> As specified in <i>Appendix E-2, Item b</i> , the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
<input checked="" type="checkbox"/>	<b>Both Authorities.</b> The waiver provides for both participant direction opportunities as specified in <i>Appendix E-2</i> . Supports and protections are available for participants who exercise these authorities.

**c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

<input checked="" type="checkbox"/>	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
<input type="checkbox"/>	Participant direction opportunities are available to individuals who reside in other living

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	arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
<input type="checkbox"/>	The participant direction opportunities are available to persons in the following other living arrangements ( <i>specify</i> ):

**d. Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

<input type="radio"/>	Waiver is designed to support only individuals who want to direct their services.
<input checked="" type="checkbox"/>	The waiver is designed to afford every participant (or the participant’s representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="radio"/>	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. <i>Specify the criteria:</i>

**e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant’s representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

<p>Intake and Evaluation staff provide information about participant direction opportunities in the New Options Waiver Program to all individuals applying for this program. Information provided at the time of application highlights the key differences between participant-directed waiver services and provider-managed waiver services in terms of the benefits, risks and responsibilities of each type of service delivery. The information is provided verbally and in writing. Support Coordinators provide additional information about participant direction opportunities to individuals and their representatives as they wait for waiver service delivery to begin. Information is provided verbally and is individualized based on requests by individuals or representatives and an assessment by the Support Coordinator of the need for additional information. Support Coordinators also assist informed decision-making by individuals and their representatives about the election of participant direction during the development of the Individual Service Plan with information and training on the benefits, risks and responsibilities assumed by those who elect participant direction. Information is provided verbally and in writing. Support Coordinators provide waiver participants and their representatives who elect participant direction with a copy of the NOW Handbook on Participant Direction, which includes state policies and procedures for participant direction.</p>	
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**f. Participant Direction by a Representative.** Specify the State’s policy concerning the direction of waiver services by a representative (*select one*):

<input type="radio"/>	The State does not provide for the direction of waiver services by a representative.
<input checked="" type="checkbox"/>	The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/>	Waiver services may be directed by a legal representative of the participant.

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<input checked="" type="checkbox"/>	<p>Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:</p> <p>Support Coordinators inform waiver participants that a representative may assist with participant-direction responsibilities. Adult waiver participants freely choose their non-legal representative. An adult waiver participant’s Support Coordinator assists him or her in choosing an appropriate, qualified representative who will serve in his or her best interests. Whenever an adult waiver participant chooses a non-legal representative, his or her Support Coordinator assures at least an annual review of whether the continued direction of waiver services by the non-legal representative is in the best interests of the adult waiver participant. Representatives must follow all requirements related to the direction of waiver services, including signed documentation of their understanding of their role and responsibilities as a representative. Support Coordinators assist the representative in the development of the Individual Service Plan and the Individual Budget for participant direction. Community Guides provide, if needed, direct assistance to the representative on ISP and Individual Budget development that support community connections. Support Coordinators assure that representatives direct the inclusion of items in the Individual Budget that tie to specific ISP goals, which are based on the individual needs of the waiver participant. Under no circumstances may a representative for an individual in participant direction be approved to be the provider of service. The Financial Support Services only pays for services specified in the Individual Service Plan, and Support Coordinators additionally monitor the provision of these services in relation to ISP goals, the health and safety of the waiver participant, and the meeting of all participant-direction responsibilities.</p>
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**g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. *(Check the opportunity or opportunities available for each service):*

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Community Guide	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Community Access	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Supported Employment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Community Living Support	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Respite	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Transportation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Natural Support Training	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Individual Directed Goods and Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Specialized Medical Equipment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Specialized Medical Supplies	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Vehicle Adaptation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Environmental Accessibility Adaptation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Adult Physical Therapy Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Adult Occupational Therapy Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Adult Speech and Language Therapy Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

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Behavioral Supports Consultation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
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**h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

<input checked="" type="checkbox"/>	<b>Yes.</b> Financial Management Services are furnished through a third party entity. <i>(Complete item E-1-i).</i> Specify whether governmental and/or private entities furnish these services. <i>Check each that applies:</i>
<input type="checkbox"/>	Governmental entities
<input checked="" type="checkbox"/>	Private entities
<input type="checkbox"/>	<b>No.</b> Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. <i>Do not complete Item E-1-i.</i>

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

<input checked="" type="checkbox"/>	FMS are covered as the waiver service entitled <span style="border: 1px solid black; padding: 2px;">Financial Support Services</span> as specified in Appendix C-3.
<input type="checkbox"/>	FMS are provided as an administrative activity. <i>Provide the following information:</i>
<b>i.</b>	<b>Types of Entities:</b> Specify the types of entities that furnish FMS and the method of procuring these services:  
<b>ii.</b>	<b>Payment for FMS.</b> Specify how FMS entities are compensated for the administrative activities that they perform:  
<b>iii.</b>	<b>Scope of FMS.</b> Specify the scope of the supports that FMS entities provide <i>(check each that applies):</i>
<i>Supports furnished when the participant is the employer of direct support workers:</i>	
<input type="checkbox"/>	Assist participant in verifying support worker citizenship status
<input type="checkbox"/>	Collect and process timesheets of support workers
<input type="checkbox"/>	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
<input type="checkbox"/>	Other <i>(specify):</i>  
<i>Supports furnished when the participant exercises budget authority:</i>	
<input type="checkbox"/>	Maintain a separate account for each participant's participant-directed budget
<input type="checkbox"/>	Track and report participant funds, disbursements and the balance-of participant funds
<input type="checkbox"/>	Process and pay invoices for goods and services approved in the service plan
<input type="checkbox"/>	Provide participant with periodic reports of expenditures and the status of the participant-directed budget

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	<input type="checkbox"/>	Other services and supports ( <i>specify</i> ):
		<i>Additional functions/activities:</i>
	<input type="checkbox"/>	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
	<input type="checkbox"/>	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
	<input type="checkbox"/>	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
	<input type="checkbox"/>	Other ( <i>specify</i> ):
<b>iv.</b>		<b>Oversight of FMS Entities.</b> Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

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

<input checked="" type="checkbox"/>	<p><b>Case Management Activity.</b> Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. <i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:</i></p> <p>Support Coordinators provide the following information and assistance in support of participant direction for those who elect either the Employer or Budget Authority:</p> <ul style="list-style-type: none"> <li>• Informing the participant or representative of the benefits, risks and responsibilities of participant direction;</li> <li>• Assessing the participant or representative who request participant direction to determine the ability to assume the responsibilities of participant direction, consisting of, where applicable, being the employer of support workers;</li> <li>• Informing the participant that a representative may assist him or her with participant direction;</li> <li>• Informing the participant or representative about freedom of choice of providers, individual rights, and the grievance process;</li> <li>• Assisting the participant or representative with the development of the individual emergency back-up plan;</li> <li>• Assisting the participant or representative with the development of risk management agreements;</li> <li>• Arranging Community Guide services to provide direct assistance with participant direction responsibilities, including participant-directed budget development, training to be effective employers of support workers (if applicable), and brokering of available community resources;</li> <li>• Providing the participant or representative with the process for changing the Individual Service Plan and the individual budget and the reassessment and review schedules;</li> <li>• Informing the participant or representative of state policies and procedures for participant direction;</li> <li>• Assisting the participant or representative with recognizing and reporting critical events and with identifying and managing known and potential risk;</li> <li>• Linking the participant or representative to the training and technical assistance provided by the Financial Support Services provider;</li> <li>• Monitoring participant-directed services, in conjunction with the employer supervision provided by the participant or representative (if applicable), in order to ensure quality of care and to protect the health and safety of the participant.</li> </ul>
<input checked="" type="checkbox"/>	<p><b>Waiver Service Coverage.</b> Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled: <span style="border: 1px solid black; padding: 2px;">Community Guide</span></p>

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<input type="checkbox"/>	<p><b>Administrative Activity.</b> Information and assistance in support of participant direction are furnished as an administrative activity. <i>Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:</i></p>

**k. Independent Advocacy** (select one).

<input checked="" type="checkbox"/>	<p><b>Yes.</b> Independent advocacy is available to participants who direct their services. <i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i></p> <p>DHR enters into agreements with individual advocates or advocacy organizations to furnish independent advocacy as needed for participants who direct their services. The individuals or organizations that provide independent advocacy do not provide other direct services to the participant, perform assessments, or conduct waiver monitoring, oversight or fiscal functions that have a direct impact on a participant. Independent advocacy assists participants and their representatives in mediation, conflict resolution, or problem solution in respect to any of their waiver service, including those they direct. Support Coordinators are responsible for informing participants and their representatives of the availability of independent advocacy and arranging for this advocacy as needed.</p>
<input type="checkbox"/>	<p><b>No.</b> Arrangements have not been made for independent advocacy.</p>

**l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

<p>A participant or representative may voluntarily decide to terminate participant direction and return to provider-managed services. The participant or representative contacts the Support Coordinator for a meeting to revise the ISP. The Support Coordinator is responsible for a timely revision of the ISP, ensuring continuity in services by linking the participant to alternate waiver providers, and assuring the participant’s health and welfare during the transition period. Monitoring by the Support Coordinator occurs at the frequency needed during the transition period to assure the participant’s health and safety.</p>
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**m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

<p>Involuntary termination of participant direction occurs due to the failure of the participant or representative to meet the responsibilities of participant direction or because of identified health and safety issues for the participant. Failure to meet the responsibilities of participant direction include inability to complete accurately and timely all FSS required documentation, to manage the budget, and/or to meet the employer responsibilities. Health and safety issues include maltreatment of participants and occurrence of high-risk situations. Unreported fraud and misuse of funds also result in involuntary termination of participant direction. Upon the occurrence of a circumstance calling for the involuntary termination of participant direction, the Support Coordinator immediately begins planning and implementing participant access to provider-managed services. The Support Coordinator notifies the participant and/or representative of the return to provider-managed services and reports health, safety or abuse concerns or fraud to the appropriate state agencies. The Support Coordinator is responsible for ensuring continuity in services by linking the participant to alternate</p>
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waiver providers and assuring the participant’s health and welfare during the transition period. The waiver participant who is returned to provider-managed services due to involuntary termination of participant direction has no rights to appeal the decision to terminate.

- n. **Goals for Participant Direction.** In the following table, provide the State’s goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

<b>Table E-1-n</b>		
	<b>Employer Authority Only</b>	<b>Budget Authority Only or Budget Authority in Combination with Employer Authority</b>
<b>Waiver Year</b>	<b>Number of Participants</b>	<b>Number of Participants</b>
<b>Year 1</b>		105
<b>Year 2</b>		325
<b>Year 3</b>		590
<b>Year 4</b>		1070
<b>Year 5</b>		1942

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## Appendix E-2: Opportunities for Participant-Direction

**a. Participant – Employer Authority** (Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b)

**i. Participant Employer Status.** Specify the participant’s employer status under the waiver. Check each that applies:

<input checked="" type="checkbox"/>	<p><b>Participant/Co-Employer.</b> The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. <i>Specify the types of agencies (a.k.a., “agencies with choice”) that serve as co-employers of participant-selected staff:</i></p> <p>Agency Providers of Community Access, Supported Employment, Community Living Support, Community Guide, Transportation, or Respite Services.</p>
<input checked="" type="checkbox"/>	<p><b>Participant/Common Law Employer.</b> The participant (or the participant’s representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.</p>

**ii. Participant Decision Making Authority.** The participant (or the participant’s representative) has decision making authority over workers who provide waiver services. Check the decision making authorities that participants exercise:

<input checked="" type="checkbox"/>	Recruit staff
<input checked="" type="checkbox"/>	Refer staff to agency for hiring (co-employer)
<input type="checkbox"/>	Select staff from worker registry
<input checked="" type="checkbox"/>	Hire staff (common law employer)
<input checked="" type="checkbox"/>	Verify staff qualifications
<input checked="" type="checkbox"/>	<p>Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:</p> <p>The Financial Support Services rate includes criminal records checks of support workers hired by the participant or representative acting as the employer of record. Contracted service providers acting as an agency of choice arrange for criminal records checks when the co-employer with a participant or representative.</p>
	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
<input checked="" type="checkbox"/>	Determine staff duties consistent with the service specifications in Appendix C-3.
<input checked="" type="checkbox"/>	Determine staff wages and benefits subject to applicable State limits
<input checked="" type="checkbox"/>	Schedule staff
<input checked="" type="checkbox"/>	Orient and instruct-staff in duties
<input checked="" type="checkbox"/>	Supervise staff
<input checked="" type="checkbox"/>	Evaluate staff performance
<input checked="" type="checkbox"/>	Verify time worked by staff and approve time sheets
<input checked="" type="checkbox"/>	Discharge staff (common law employer)

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<input type="checkbox"/>	Discharge staff from providing services (co-employer)
<input checked="" type="checkbox"/>	Other ( <i>specify</i> ):
	Recommend discharging staff from providing services (co-employer)

**b. Participant – Budget Authority** (*Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b*)

**i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply:*

<input checked="" type="checkbox"/>	Reallocate funds among services included in the budget
<input checked="" type="checkbox"/>	Determine the amount paid for services within the State’s established limits
<input checked="" type="checkbox"/>	Substitute service providers
<input checked="" type="checkbox"/>	Schedule the provision of services
<input checked="" type="checkbox"/>	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
<input checked="" type="checkbox"/>	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
<input checked="" type="checkbox"/>	Identify service providers and refer for provider enrollment
<input checked="" type="checkbox"/>	Authorize payment for waiver goods and services
<input checked="" type="checkbox"/>	Review and approve provider invoices for services rendered
<input type="checkbox"/>	Other ( <i>specify</i> ):

**ii. Participant-Directed Budget.** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The individualized budgeting process in the NOW Program ties waiver allocations to direct assessments of the support needs of participants. The NOW Program utilizes the Supports Intensity Scale (SIS), a standardized assessment of support needs, for annual participant-centered assessment and as the foundation for the development of the Individual Service Plan (ISP). The SIS assessment provides individual support needs data from a direct assessment of the support needs of an individual with mental retardation and/or a developmental disability. This direct assessment of support needs is an improvement from other assessment instruments (e.g., Inventory for Client and Agency Planning) that statistically infer support needs based on historical correlations of need and adaptive/maladaptive behavior scores. The statistical approaches to need assessment treat “used” supports the same as “needed” supports. Used supports often reflect resource availability and program philosophy more than actual needed supports. Statistical approaches also make an inference about an individual based on aggregate data for a group when in fact the inference—in this case, type(s) and level(s) of needed support—is unlikely to make sense for every member of the group. Given the advantages of a direct assessment of need, the NOW Program utilizes the SIS as the cornerstone for the determination of the amount of the participant-directed budget. SIS data form the basis for individualized budgeting in the NOW, as described in Appendix C-4.

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

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The Support Coordinator informs the participant of the amount of the participant-directed budget during the Individual Service Plan development process. The amount of the participant-directed budget is the amount of the individual waiver allocation remaining after any costs for provider-managed services. In the event of changed needs by a waiver participant, an ISP review meeting may be called by the participant's support coordinator or at the request of a participant or representative who opt for participant direction. If the interdisciplinary team review determines a need for increased intensity of services, the Intake & Evaluation Manager or designee may approve a time-limited increase in intensity of services. If it is determined that a waiver participant has an extended need for an increased intensity of services, the individual is referred to the Comprehensive Supports Waiver Program. Waiver participants may request a Fair Hearing according to the procedures outlined in Appendix F when the participant's request for an adjustment to the budget is denied or the amount of the budget is reduced. Support coordinators are required to inform waiver participants of their rights to request a Fair Hearing.

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

<input type="radio"/>	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
<input checked="" type="checkbox"/>	Modifications to the participant-directed budget must be preceded by a change in the service plan.

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The FSS provider is responsible for generating utilization/expenditure reports twice monthly in a declining balance format for participants and their families/representatives. The FSS provider

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

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# Appendix F: Participant Rights

## Appendix F-1: Opportunity to Request a Fair Hearing

*The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.*

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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

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

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## Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

<input type="radio"/>	<b>Yes.</b> The State operates an additional dispute resolution process ( <i>complete Item b</i> )
<input checked="" type="checkbox"/>	<b>No.</b> This Appendix does not apply ( <i>do not complete Item b</i> )

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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## Appendix F-3: State Grievance/Complaint System

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

<input checked="" type="checkbox"/>	<b>Yes.</b> The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver <i>(complete the remaining items)</i> .
<input type="checkbox"/>	<b>No.</b> This Appendix does not apply <i>(do not complete the remaining items)</i>

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

DHR's Division of MHDDAD is responsible for the operation of the grievance/complaint system.
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**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

<p>DHR, Rules and Regulations Chapter 290-4-9 specify that any consumer (or his guardian or parent of a minor consumer, if applicable) or his representative or any staff member may file a complaint alleging that a consumer's rights under these regulations or other applicable law have been violated by staff members or persons under their control. Such complaints shall be governed by the procedure established in this Section 290-4-9-.04. A person who considers filing such a complaint is encouraged to resolve the matter informally by discussing it first with the staff members or other persons involved or Program Consumers' Right staff as specified in the Program's Quality Improvement Plan. The consumer is not required to use the procedures established by this Section 290-4-9-.04 in lieu of other available remedies, including the right to directly contact the Personal Advocacy Unit at the Division of MHDDAD or to submit a written complaint to the Regional Coordinator, Program Director or Governor's Advisory Council as provided in O.C.G.A. Chapter 37.2.4. Waiver participants are informed that the filing of complaints is not a prerequisite or substitute for a Fair Hearing, as described in Appendix F-1</p> <p>In order to ensure that such internal quality improvement investigations and monitoring activities are completed fully and in an in-depth manner, to encourage candid evaluations, and to ensure that adequate corrective action is taken in all cases, review actions taken and documentation made in furtherance of this Section 290-4-9-.04 remain confidential.</p> <p>Each Program Director appoints a Consumers' Rights Subcommittee to review the rights of the consumers receiving services from programs contracted by the Department either directly or indirectly. The Consumers' Rights Subcommittee functions as a part of the program's ongoing quality improvement program, as described in the Program's Quality Improvement Plan.</p> <p>The complaint is filed with the Consumers' Rights Subcommittee of the consumer's program, and it may be filed on a form provided by the consumer's program. If the consumer states the complaint orally, specific assistance is given in proceeding with the complaint and completing the form. Complaints may be made by telephone to consumers' rights staff persons, who complete the form. Staff members whose alleged conduct gave rise to the complaint may be informed of the complaint.</p>
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The complaint is filed with the Consumers' Rights Subcommittee of the consumer's program, and it may be filed on a form provided by the consumer's program. If the consumer states the complaint orally, specific assistance is given in proceeding with the complaint and completing the form. Complaints may be made by telephone to consumers' rights staff persons, who complete the form. Staff members whose alleged conduct gave rise to the complaint may be informed of the complaint.

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

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

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

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

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

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Coordinator's rejection or decision, together with a copy of the previous reviewer's recommendations, the Program Director's decision, and other documents utilized in the review, if any.

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

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

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

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

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# Appendix G: Participant Safeguards

## Appendix G-1: Response to Critical Events or Incidents

- a. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

### **POLICY**

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

### **DEFINITIONS**

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

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

### **PROCEDURES**

#### **A. Reporting deaths**

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

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- enforcement has not called the coroner/medical examiner;
  - b. Calls the guardian, if any, and/or next of kin of the deceased after authorization from the coroner/medical examiner;
  - c. In the case of a child’s death in a state hospital, designates a staff person, who is qualified to provide crisis/grief counseling, to notify the parent/guardian in person of the death;
  - d. Notifies the support coordinator, if applicable, within 24 hours; and
  - e. In instances when the DHR Division of Family and Children Services, Department of Juvenile Justice, or Adult Protective Services has custodial or commitment responsibility, notifies the worker within 24 hours.
3. The community provider immediately reports by phone all unexplained or suspicious deaths to the Division of MHDDAD Investigations Section. This call must be made as soon as possible, but at least within two (2) hours of the death. The provider presents any information available at the time of the telephone report that is required on the Critical Incident Report form. A copy of the Critical Incident Report form must be submitted on the same day as the consumer’s death or on the next business day if the death occurred after business hours or on a weekend or holiday. The senior executive manager is responsible for ensuring that both the telephone notification and the written Critical Incident Report are submitted as required.
  4. For all unexplained or suspicious deaths, the Division of MHDDAD Investigations Section notifies the Director of MHDDAD, the Division Medical Director and the Regional Coordinator immediately.
  5. For all other consumer deaths, the community provider transmits, by fax or electronically, the Critical Incident Report form to the Division of MHDDAD Investigations Section. The report must be submitted on the same day as the consumer’s death or on the next business day if the death occurred after business hours or on a weekend or holiday.

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

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

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

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

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

**D. Reporting to DCH**

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

- b. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

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

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

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

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

- c. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

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

**A. Administrative Review of Critical Incident Report form**

1. Community providers perform an administrative review of all *Critical Incident Reports*. The administrative review includes, at a minimum:
  - Reading the *Critical Incident Report*;
  - Reading all statements and reports associated with the incident;
  - Requiring and ensuring the completion of any incomplete or missing documentation; and
  - Signing as the administrative reviewer on the *Critical Incident Report* form.
2. Community providers (including state-operated community programs) define in their internal policy the supervisory staff appropriate and available to perform the administrative review of all *Critical Incident Report* forms.
3. The Investigations Section reviews all *Critical Incident Reports* for completeness and contacts the community provider for changes and additional information, as appropriate.
4. The Investigations Section in all cases obtains a copy of the death certificate from the DHR Division of Public Health. This copy may not be reproduced or released outside the Division of MHDDAD.

**B. Computer data entry**

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

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database to identify patterns and to perform trend analyses.

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

**C. Investigations of Critical Incidents**

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

**D. Corrective Action Plans and Follow-up**

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

**E. Procedures for Data Analysis**

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

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

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

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## Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

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

**a. Applicability. Select one:**

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

**b. Safeguards Concerning Use of Restraints or Seclusion**

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

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

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

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

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

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

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

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

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

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

Providers are required to complete an incident report and send to the State any time in the use of restrictive interventions an injury ensues and that injury requires any level of treatment, including

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

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

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

**c. Safeguards Concerning the Use of Restrictive Interventions**

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

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

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

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

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

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

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

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

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

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## Appendix G-3: Medication Management and Administration

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

<input type="radio"/>	<b>Yes.</b> This Appendix applies ( <i>complete the remaining items</i> ).
<input checked="" type="checkbox"/>	<b>No.</b> This Appendix is not applicable ( <i>do not complete the remaining items</i> ).

**b. Medication Management and Follow-Up**

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

**ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

**c. Medication Administration by Waiver Providers**

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

<input type="radio"/>	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. ( <i>complete the remaining items</i> )
<input type="radio"/>	Not applicable ( <i>do not complete the remaining items</i> )

**ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

<input type="radio"/>	Providers that are responsible for medication administration are required to <i>both</i> record and report medication errors to a State agency (or agencies). <i>Complete the following three items:</i>
	(a) Specify State agency (or agencies) to which errors are reported: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	(b) Specify the types of medication errors that providers are required to <i>record</i> : <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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	(c) Specify the types of medication errors that providers must <i>report</i> to the State:
	○ Providers responsible for medication administration are required to <i>record</i> medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

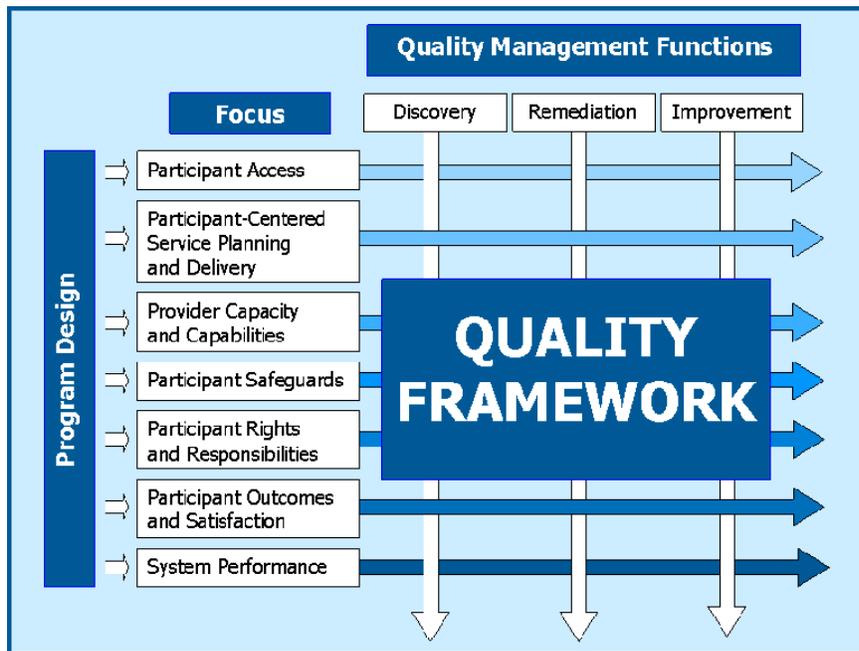
- iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

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# Appendix H: Quality Management Strategy

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.



Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement. A Quality Management Strategy explicitly describes the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state’s waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

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

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**Quality Management Strategy: Minimum Components**

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

**1. The Quality Management Strategy must describe how the state will determine that each waiver assurance and requirement is met.** The applicable assurances and requirements are: (a) level of care determination; (b) service plan; (c) qualified providers; (d) health and welfare; (e) administrative authority; and, (f) financial accountability. For each waiver assurance, this description must include:

- Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices A, B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
- The entities or individuals responsible for conducting the discovery/monitoring processes;
- The types of information used to measure performance; and,
- The frequency with which performance is measured.

**2. The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants, advocates, and service providers.**

*Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.*

**3. Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.** *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in # 2 above.*

**4. The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public.** *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*

**5. The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy.**

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

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When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

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## Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

### Quality Management Strategy for Developmental Disabilities Services

#### Introduction

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

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

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

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

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

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

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

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

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

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

**H.1.a: Level of Care**

**Current LOC Quality Management Strategies**

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

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

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

- C. The Division contracts with an external agency to conduct Individual Records Audits on a yearly basis. Documentation regarding the LOC process is considered as part of this external review. Approximately 10% of all waiver records are reviewed.
- D. Regional Offices are assigned the task of reviewing discovery data as well as identifying and remediating underlying problems that lead to negative findings. Each Regional Office reviews and approves Individual Service Plans and Level of Care documentation. The Office of DD monitors the remediation process.

### **Proposed Redesign of the LOC Quality Management Strategy**

#### **Web-Based Management System**

- A. The web-based management system is to record Initial Application for Services data including:
  - 1. Date of completion of various parts of the process
  - 2. Copy of Application, Intake Screening Summary and ancillary notes and testing required to determine eligibility with schedule and completion dates
- B. The web-based management system is to record and track participants' initial and annual LOC assessments (with approved instruments) including:
  - 1. Supports Intensity Scale
  - 2. Health Risk Screening Tool
  - 3. Social Work, Nursing, Psychological and Therapy Assessments
  - 4. DMA-6 (LOC determination form)
- C. The Web-based management system is to provide follow up data including pending LOC expirations, participants' transfers across regions and participants' discharge from services
- D. Regional Offices review and evaluate the LOC data collected. Protocols on review of LOC reports are expected to be in practice by the sixth month of waiver implementation.
- E. The Office of Developmental Disabilities is to research best practice quality management strategies for monitoring LOC decisions and addressing inappropriate LOC determinations. LOC quality indicators are to be established and a review and remediation protocol is to be designed including identification of the parties/entities responsible for implementation by the end of the first month of waiver implementation.

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

#### **Current POC Quality Management Strategies**

- A. WIS provides reports related to the management of ISP's. The "Participant ISP Expiration Report" is reviewed by Operations Analysts in the Regional Offices. The "Participant ISP Due Report" is used as a workload management tool that projects ISP's due within the next 30, 60 and 90 days. ISP compliance reports are shared with DCH as part of their oversight.
- B. Division and I&E staff meet at least quarterly. The LOC process and WIS data are discussed. Any negative trends are noted and, as necessary, plans for remediation and improvement are developed and implemented. Such remediation and improvement strategies and implementation results are discussed

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with DCH in the quarterly DMHDDAD/DCH meetings.

- C. ISP samples are reviewed by state office staff on a quarterly basis. Weaknesses are noted and trended. Statewide training on the ISP is developed and provided by the Division and contracted staff. Input is sought from stakeholders including Support Coordination, I&E, and service provider staff regarding the content and presentation format of ISP training.
- D. Regional Office staff review five (5) to ten (10) percent of all Individual Service Plans on a monthly basis. Audit results are shared with support coordination agencies and the Office of DD with the expectation that providers address identified issues.
- E. Support Coordinators facilitate ISP meetings and the development of the plan. Support Coordinators monitor and report on service delivery to document that services detailed in the plan are being delivered as prescribed (see Appendix D-2). All negative provider ratings are reviewed by the Health and Human Rights Coordinator in the Office of Developmental Disabilities. Findings are trended by type and provider. Trends are reported to Office of Developmental Disabilities staff and decisions are made regarding remediation and quality improvement. (For more on support coordination oversight, see Appendix H.1.d on Health and Safety).
- F. The annual Individual Records Audit by an external contacted agency includes a review of ISP's. ISP's are assessed for completeness and quality. The review agency reports findings to the Office of Developmental Disabilities. Findings of the review become the focus of statewide ISP training in the next year.

### **Proposed Redesign of the POC Quality Management Strategy**

#### **Web-based Management System**

- A. The web-based management system is to record and track data required for follow up including:
  - 1. Convert the ISP format to electronic format
  - 2. Provide for secure electronic signatures
  - 3. Maintain SIS data
- B. The web-based management system is to:
  - 1. Record and track ISP due dates, ISP meeting schedules, and dates of actual meetings
  - 2. Sort ISP Scheduling issues by:
    - a. Service Provider, Region, Support Coordination Agency, and Support Coordinator
    - b. Time and Location of ISP meetings
    - c. Cancellations and Reasons for Cancellation
- C. A full description of the role of the new data management system as a part of quality management of the ISP is to be included in the waiver's Year 1 annual report to CMS.

#### **Supports Intensity Scale**

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

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### **National Core Indicators Project**

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

### **Transition for ICF/MR to Community Services**

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

### **H-1-c: Qualified Providers**

### **Current Provider Qualification Quality Management Strategies**

#### **Licensing**

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

#### **Provider Approval**

- A. Provider enrollment for all services requires documentation of provider and staff qualifications and the organization's capacity to provide services. Provider applications are evaluated by designated staff in the Division's Provider Certification Unit. If approval is recommended by the Provider Certification Unit, applications are forwarded to DCH for final review and approval.
- B. Support Coordinators complete site visits on all residential settings prior to participants moving into any setting. Sites may not be occupied until all requirements are satisfied.
- C. Division policy requires most direct service providers agencies (i.e., all providers contracting with DHR through the division and its regional offices, or receiving funding through the division, in an amount of \$250,000 or more per year) to be qualified and appropriately accredited through one of the following nationally recognized accreditation agencies:
  - 1. The Council on Quality and Leadership
  - 2. Commission on Accreditation of Rehabilitation Facilities (CARF)
  - 3. Joint Council on Accreditation of Healthcare Organizations
  - 4. Council on Accreditation (COA)
- D. Division policy requires all remaining direct service providers to be certified by the Division of Mental Health, Developmental Disabilities and Addictive Diseases.
- E. Verification occurs that providers continue to meet requirements.

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- F. Each region has responsibility for evaluating the provider network.
  - 1. Providers under accreditation are reviewed by the accreditation bodies at least every three years.
  - 2. Providers under certification are reviewed by MHDDAD every two years and must be in compliance with all MHDDAD core standards before certification is granted.
  - 3. Each region reviews provider accreditation and certification status annually at the time of contract renewal.
  - 4. Support Coordinators document and report to MHDDAD Regional Offices that providers are properly licensed or no longer properly licensed as a routine part of the support coordination monitoring process.
- G. Identification and Remediation of Poor Provider Performance
- H. The Division of MHDDAD identifies issues of concern using a variety of mechanisms, including:
  - 1. the Death and Serious Incident Reporting System
  - 2. failure of a provider to meet re-accreditation or re-certification
  - 3. aggregated reviews conducted by Support Coordinators
  - 4. concerns received by the Division from any credible source
  - 5. negative results from Division consumer and family satisfaction surveys
  - 6. failure to meet MHDDAD core standards during Special Reviews
- I. State Office and regional staff discuss findings from the review of various discovery sources. Given the findings, Division staff may decide on any number of remediation and quality improvement processes.
- J. If serious health and safety concerns are identified, the Division, in collaboration with DCH may decide to revoke the agency's provider number, cease doing business with the agency and move the participants to qualified provider agencies.
- K. If there are concerns relating to payment by Medicaid for services not documented as rendered, the information is forwarded to the Program Integrity Unit in DCH, which conducts its own investigation.
- L. Information about the activities of the Division of MHDDAD, including provider issues, is shared with DCH at the Joint Quarterly Meeting. DCH may request additional information as deemed necessary.

**Provider Profile System**

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

**Proposed Redesign of Provider Qualification Quality Management Strategies**

**Establishment of Position of Coordinator of Provider Training and Development**

The Division of MHDDAD has a dedicated position within the Office of Developmental Disabilities Services with responsibility of developing a strong and stable community provider system based on best evidence-based practices in the field of disabilities. Initial provider training and development initiatives are workforce development, establishment of a provider forum, and improvements in provider database, enrollment, certification, and licensure. Additional initiatives are to be identified through trend analysis.

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**Direct Support Professional Certification Program**

- A. Well trained staff have a positive effect on service quality and the well-being of persons served. One of the major projects of Georgia’s Real Choice System Change Grant awarded by CMS in 2001 to Georgia was development of a direct support professional certificate program through Georgia’s technical colleges. In collaboration with the Governor’s Council on Developmental Disabilities and with the Department of Adult and Technical Education, MHDDAD launched this program at four state technical colleges during the Fall Quarter 2004. This very successful program has continued expansion with new classes at additional colleges each quarter. Reaction to the certification program has been extremely positive from participants (Direct Support Professionals) and their employers.
- B. The Office of Developmental Disabilities is interested in further identifying desired outcomes for the Direct Support Professional Certification Program, specifying indicators and developing data collection procedures to be used in the measurement of those outcomes. Results are to be used by the Division and other stakeholders in decision making regarding future funding, expansion, and incentives for participants. The Division is collaborating with other stakeholders, including the Governors Council on Developmental Disabilities and the Department of Adult and Technical Education, to form an Outcome Measurement Work Group by September, 2006. This group is to have the responsibility of defining outcomes, specifying indicators, and developing the data collection system. Data collection is to begin in the Spring Quarter, 2007, and data are to be analyzed and findings reported by Fall Quarter 2007.

**Provider Profile System**

- A. Due to data systems limitations and confidentiality concerns, the Provider Profile System has never accomplished all of the functions or yielded all of the results that were envisioned when it was established. Most notably, none of the data in the system is currently available to participants or families. Without adequate information on provider agency strengths and weaknesses, informed choice in provider selection is compromised.
- B. The Office of DD is working with the Office of Investigations and the DHR Office of Technology to improve the Provider Profile System, including making provider performance data available to participants. The Quality Management System Work Group in the Office of DD is to complete research on other states’ provider profiling systems by October 1, 2006. The Work Group is to present alternatives and recommendations to the Office of Investigations and the DHR Office of Technology by November 15, 2006. The target date for an updated Provider Profile System with the capacity to inform participants and their families in provider selection is July 1, 2007.

**Provider Enrollment System**

- A. At present, Georgia’s DD provider enrollment system is unsatisfactory. The chief concerns are:
  - 1. Providers that do not have the capacity to deliver quality services or assure participants’ health and safety may receive approval, and
  - 2. The time period between the provider application to actual provider approval (and the assignment of Medicaid Waiver provider numbers) is so long as to discourage qualified providers from beginning or completing the application process.
- B. Neither of these circumstances is acceptable. The Office of DD is proposing a redesigned provider assessment and enrollment system. The Office of DD’s Provider Application Development Work Group is to be responsible for initial research regarding provider enrollment best practices. In collaboration with a range of internal and external stakeholders, the Work Group is to create a list of the strengths/capacities that successful service provider organizations should be expected to have (by individual waiver service). Given clarity regarding the necessary strengths/capacities, the expanded Work Group (including other stakeholders) is to develop application criteria that can assist in

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documenting that an applicant provider is qualified. Finally, the review and approval process is to be studied and changes made to assure that the provider application and approval process is efficient and facilitates the process of getting qualified providers approved and available to begin service provision. Redesign of the provider qualification system is expected to be completed by July 1, 2007.

#### **H-1-d Health and Safety**

### **Current Health and Safety Quality Management Strategies**

#### **Health and Risk Assessments**

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

#### **Support Coordination**

- A. Monitoring the health and welfare of participants is the primary responsibility of Support Coordinators. The Support Coordination monitoring, reporting and review process, along with remediation and quality improvement strategies have been described earlier (Appendix H.1.c. Qualified Providers).
- B. According to review results, the most common negative findings reported by Support Coordinators involve errors in documentation of medication administration. Statewide trainings and individual provider technical assistance on medication administration (including documentation) have been presented by Office of DD and Office of Provider Certification staff.

#### **Critical Incidents Reporting System**

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

### **Proposed Redesign of Health and Safety Quality Management Strategy**

#### **Human Rights Committees**

- A. The Office of Developmental Disabilities has determined that service quality could be enhanced and participants could be better protected through the establishment of a statewide network of approximately forty (40) Human Rights Committees (HRC's). In March 2006, the Office of Disabilities filled the newly designed position of Coordinator of Health and Human Rights. A chief responsibility of the position is to establish the network of Human Rights Committees. By the end of state FY'07, approximately 40 HRC's are to serve participants in 36 DD Service Areas.
- B. The role of the committees is defined as follows: Human Rights Committees are groups of local citizens who provide independent oversight as a local intermediary structure in matters related to the rights of citizens with developmental disabilities who reside in the state of Georgia. Examples of types of issues/concerns to be reviewed by HRC's include: mistreatment, abuse, neglect, exploitation, misuse of pharmaceuticals, restraints and behavioral programs and interventions. Volunteer membership is to include medical professionals, pharmacist/medication experts, self advocates, other advocates, parents, other family members, law enforcement personnel, business people, and representatives of faith-based organizations.

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

**National Core Indicators Project (NCI)**

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

**Increasing Staff and Provider Capacity**

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

**Medication Administration**

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

**Provider Review System**

As indicated in the introduction, the Division is able to add Provider Certification staff in FY'07 as a result of additional DD "infrastructure" funding. The Office of DD is proposing a redesign of the Division's provider certification review process. The addition of DD designated staff expands certification review capacity in the Division's Provider Certification Unit. The Office of DD is proposing that all DD providers be certified through a Division certification process. The proposed review process would be led by Provider Certification Unit staff, but the review team would include external stakeholders such as other providers, people with disabilities, family participants, and provider agency board participants. The proposed schedule for such reviews would be every two (2) to three (3) years. Discussions on this proposal have already begun between staff in the Office of DD and the Provider Certification Unit. Other internal and external stakeholders (including providers) are to be brought into these discussions. The Office of DD is hopeful that a redesigned and more efficient and effective provider review process can be implemented no later than the middle of the second year of the waiver.

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#### **H.1.e. Administrative Authority**

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

#### **H.1.f. Financial Accountability**

- A. The Utilization Management Program, operated by the Office of Developmental Disabilities and regional Operations Analyst staff, is a coordinated and comprehensive program designed to monitor waiver access to eligible persons in Georgia. Discovery is expected to increase waiver efficiency and service effectiveness by allowing Division staff to:
1. Better determine the amount, type and intensity of supports that are needed for participants
  2. Systematically implement a needs driven allocation process
  3. Maintain an integrated data system to gather and analyze financial and categorical data elements to be used in allocation and tracking of services and resources
- B. Parts of this Utilization Management Program are in place now, but full implementation is not expected until mid-year, state FY'07. Stakeholders to be included in the design and implementation include: I&E Teams, Support Coordinators, regions' provider networks, participants and their families.

### **H2: Roles and Responsibilities**

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

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

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

### **H4: Compilation and Communication of Quality Management Information**

- A. As the Quality Management Strategy is being redesigned, many decisions are yet to be made regarding reporting. At a minimum, the end of state FY'07 reporting is to include data on:
1. Numbers of individuals in Supported Employment
  2. Reductions in the number of people served in state operated ICF's/MR
  3. Types of new waiver services chosen by participants (and general evaluation of new waiver implementation)
  4. Achievement of selected critical indicators from Core Indicators Project data
  5. Timeliness and completeness of LOC's and ISP's
  6. Substantiated Critical Incidents sorted by types
  7. Various provider contract deliverables
  8. Other information determined through the Quality Management Strategy redesign effort
- B. The Office of Developmental Disabilities acknowledges that results of its various quality reviews should be communicated much more widely than is currently the case. Information should be made

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available in a participant and family friendly format. While privacy rights of all parties are to be protected, the results of investigations and any follow-up actions should be made available for public review. As discussed in Appendix H.1.c (Provider Qualifications), participants and their families should have the information they need to make informed choices about provider selection. Broader involvement of and communication with external stakeholders (particularly providers, participants and their families) in the quality improvement process are expected to facilitate the creation and strengthening of a “culture of improvement” further strengthening both the formal and natural support systems for participants.

#### **H5: Periodic Evaluation and Revision of the QMS**

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

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# Appendix I: Financial Accountability

## APPENDIX I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Program Integrity Unit (PI) is a part of the Department and is responsible for conducting the survey of provider services and billing to ensure the integrity of the payments that have been made by Medicaid to providers for waiver services. PI will annually review a random sample of a minimum of 50 of the waiver service provider records. PI will also review upon request or report any agency suspected of fraud. The 50 records are representative of all service provider types. The sample represents about 1% of all members served.

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

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

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

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

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

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In cases of recovery of reimbursement as determined, a letter of “Request for Refund” is sent to the applicable provider/s, detailing the cause for recovery, amount, and instructions for requesting an Administrative Review of the action, and request for a hearing.

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

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

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## APPENDIX I-2: Rates, Billing and Claims

- a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

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

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

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

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

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

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

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

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

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

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

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

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

**Community Living Support:** The maximum 15 minute rate per member is based on a sample review of the current FY 2007 individual budget expenses for two types of personal supports services: MRWP Natural Support Enhancement personal support services, and MRWP Consumer-Directed Natural Support Enhancement personal support services. Based on this sample review, the maximum billing rate is set at the median rate for the associated individual budget expenses which is \$3.80 per 15 minutes. Providers will bill at this rate up to a maximum amount of \$138.09 per day. The maximum annual number of 15 minute units per member is capped at 6,032 and expenditures are capped at \$22,921.60

**Respite Services:** The maximum rate per member is based on a sample review of the current FY 2007 individual budget expenses for MRWP Natural Support Enhancement respite services, and for MRWP Consumer-Directed Natural Support Enhancement respite services. Based on this review, the maximum billing rate was set at the median of associated individual budget expenses which is \$3.00 per unit of 15 minutes. The maximum annual number of units is 1,248 and the maximum annual expenditure is \$3,744.00. For overnight respite, reimbursement is set at \$96 per night (\$3.00 x 32 units) and is available for up to 13 overnight stays; however, each overnight stay counts as 24 units towards the annual fifteen-minute unit maximum of 1,248.

**Specialized Medical Supplies:** The maximum rate per member is based on the current CMS approved MRWP annual rate, as of September 2005, for Specialized Medical Supplies, which is \$1,734.48.

**Specialized Medical Equipment:** The maximum rate per member is the standard Medicaid reimbursement rate for the equipment or, in the absence of a standard Medicaid rate, the lower of three price quotes obtained from the Specialized Medical Equipment providers or the annual maximum. The annual maximum is \$5,200 based on the current CMS approved CHSS rate, as of September 2005, with a lifetime limit set at the current CMS approved MRWP amount of \$13,474.76, as of September 2005.

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

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

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

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

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

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

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**Adult Physical Therapy, Adult Occupational Therapy, Adult Speech and Language Therapy Services:**

The maximum rates for adult therapy services are the Medicaid State Plan standard reimbursement rates under Children’s Intervention Services for the covered evaluation and therapy procedures. The maximum annual expenditure for all adult therapy services is \$1,800.00.

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

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

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

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

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

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

**Natural Support Training Services:** The maximum rate is based on the current reimbursement for comparable family training service of \$20.78 per 15 minutes as provided in Georgia’s Medicaid Community Mental Health Services. The maximum annual number of service units available is 86 (one unit = 15 minutes) and maximum annual expenditures at \$1,787.08.

**Individual Directed Goods and Services:** The provider payment rate is individually determined based on the costs for the specific goods and services and is the lowest of three price quotes up to the annual maximum of \$1,500 for up to 20 units (unit = 1 item). This rate is based on the review of comparable services in other states’ DD waivers.

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

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

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by review of audit findings.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State’s claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

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

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

<input type="radio"/>	<b>Yes.</b> Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid ( <i>check each that applies</i> ):
<input type="checkbox"/>	<b>Certified Public Expenditures (CPE) of State Public Agencies.</b> Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). ( <i>Indicate source of revenue for CPEs in Item I-4-a.</i> )
<input type="checkbox"/>	<b>Certified Public Expenditures (CPE) of Non-State Public Agencies.</b> Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). ( <i>Indicate source of revenue for CPEs in Item I-4-b.</i> )
<input checked="" type="checkbox"/>	<b>No.</b> Public agencies do not certify expenditures for waiver services.

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant’s approved service plan; and, (c) the services were provided:

Georgia Law states that the Department of Community Health can process Medicaid claims only if they are received by the Department by the end of the sixth month following the month of service. To facilitate timely and correct payment to providers the Department has implemented a Medicaid Management Information System (MMIS). The system utilizes automated processing and auditing of claims.

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

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

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

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

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## APPENDIX I-3: Payment

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

<input checked="" type="checkbox"/>	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
<input type="checkbox"/>	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
<input type="checkbox"/>	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
<input type="checkbox"/>	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

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

<input checked="" type="checkbox"/>	The Medicaid agency makes payments directly to providers of waiver services.
<input checked="" type="checkbox"/>	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
<input type="checkbox"/>	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
<input type="checkbox"/>	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

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

<input checked="" type="checkbox"/>	<b>No.</b> The State does not make supplemental or enhanced payments for waiver services.
<input type="checkbox"/>	<p><b>Yes.</b> The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.</p>

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

<input type="checkbox"/>	<p><b>Yes.</b> Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. <i>Complete item I-3-e.</i></p>
<input checked="" type="checkbox"/>	<p><b>No.</b> Public providers do not receive payment for waiver services. <i>Do not complete Item I-3-e.</i></p>

- e. **Amount of Payment to Public Providers.** Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

<input type="checkbox"/>	The amount paid to public providers is the same as the amount paid to private providers of the same service.
<input type="checkbox"/>	The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
<input type="checkbox"/>	<p>The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:</p>

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

<input checked="" type="checkbox"/>	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
<input type="checkbox"/>	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
<input type="checkbox"/>	Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. **Additional Payment Arrangements**

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

<input type="checkbox"/>	<b>Yes.</b> Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
<input checked="" type="checkbox"/>	<b>No.</b> The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

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

<input checked="" type="checkbox"/>	<b>Yes.</b> The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
	(a) Enrolled Medicaid providers of the NOW service, Financial Support Services, are designated as an OHCDS. These providers function as an OHCDS by virtue of the fact that their employees furnish a waiver service.
	(b) Waiver providers may directly enroll with Medicaid to provide a service. They are not required to have an agreement/contract with an OHCDS.
	(c) The OHCDS designation is only for waiver providers of financial management

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	<p>services for participants who opt for participant direction. Participants may freely choose waiver providers who directly enroll with Medicaid or waiver providers with an agreement/contract with the OHCDS. The Intake and Evaluation Teams explain Freedom of Choice among qualified waiver providers to each participant. The participant's Support Coordinator assists him or her in choosing providers of services specified in the Individual Service Plan. This assistance may include telephonic or site visits with participants and their families, helping them access approved qualified provider lists, answering their questions about providers, and informing them of web-based information on providers. Participants are also provided a list of consumer/families available to assist in the decision-making process. MHDDAD Regional Offices periodically conduct provider fairs for participants and their families to assist with their selection of providers.</p> <p>(d) Providers submit required documentation to the OHCDS on their qualifications to provide a waiver service. The Support Coordinator reviews with the participant each provider's qualifications against the applicable provider qualifications under the waiver. The Support Coordinator and participant sign a document indicating the results of their review and submit to the OHCDS.</p> <p>(e) Submission by providers of the documentation of their qualifications to provide a waiver service and review of these qualifications against applicable provider qualifications in the waiver occurs prior to any agreement/contract between the OHCDS and the provider.</p> <p>(f) Prior authorization of waiver services is required before the delivery of any services. This prior authorization is based on the waiver services in the participant's Individual Service Plan. The DCH Policies and Procedures for the NOW specify the maintenance of necessary documentation for waiver services furnished by providers with an agreement/contract with the OHCDS.</p>
○	<p><b>No.</b> The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.</p>

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

<input type="radio"/>	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may <i>voluntarily</i> elect to receive <i>waiver</i> and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
<input type="radio"/>	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain <i>waiver</i> and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
<input checked="" type="checkbox"/>	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

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## APPENDIX I-4: Non-Federal Matching Funds

- a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

<input type="checkbox"/>	<b>Appropriation of State Tax Revenues to the State Medicaid agency</b>
<input checked="" type="checkbox"/>	<p><b>Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.</b> If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:</p> <p>Non-federal share is appropriated to the Department of Human Resources, Division of MHDDAD via the Georgia State Legislature. Funds are held in state level reserves until invoiced by the Medicaid Agency. The Medicaid Agency invoices the Division of MHDDAD on a monthly basis for all claims paid on their behalf of waiver services.</p>
<input type="checkbox"/>	<p><b>Other State Level Source(s) of Funds.</b> Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:</p>

- b. **Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

<input type="checkbox"/>	<p><b>Appropriation of Local Revenues.</b> Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:</p>
<input type="checkbox"/>	<p><b>Other non-State Level Source(s) of Funds.</b> Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:</p>
<input checked="" type="checkbox"/>	<b>Not Applicable.</b> There are no non-State level sources of funds for the non-federal share.

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- c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources. *Check each that applies.*

<input type="checkbox"/>	Provider taxes or fees
<input type="checkbox"/>	Provider donations
<input type="checkbox"/>	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:
<input checked="" type="checkbox"/>	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

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## APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

**a. Services Furnished in Residential Settings.** *Select one:*

<input type="radio"/>	No services under this waiver are furnished in residential settings other than the private residence of the individual. <i>(Do not complete Item I-5-b).</i>
<input checked="" type="checkbox"/>	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. <i>(Complete Item I-5-b)</i>

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

Respite is the only NOW service that furnishes waiver services in residential settings other than the personal home of the individual. The setting of the rates for Respite Services excludes the costs related to room and board. These rates only include the cost of direct services. No reimbursement of room and board costs occurs for Respite Services.

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## APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

### Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.

Select one:

<input type="radio"/>	<p><b>Yes.</b> Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. <i>The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:</i></p>
<input checked="" type="checkbox"/>	<p><b>No.</b> The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.</p>

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

- a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services as provided in 42 CFR §447.50. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

<input checked="" type="checkbox"/>	<b>No.</b> The State does not impose a co-payment or similar charge upon participants for waiver services. <i>(Do not complete the remaining items; proceed to Item I-7-b).</i>
<input type="checkbox"/>	<b>Yes.</b> The State imposes a co-payment or similar charge upon participants for one or more waiver services. <i>(Complete the remaining items)</i>

- i. Co-Pay Arrangement** Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies):*

<i>Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):</i>	
<input type="checkbox"/>	Nominal deductible
<input type="checkbox"/>	Coinsurance
<input type="checkbox"/>	Co-Payment
<input type="checkbox"/>	Other charge <i>(specify):</i>

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

--	--

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

Waiver Service	Amount of Charge	Basis of the Charge

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

<input type="radio"/>	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
<input type="radio"/>	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

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

b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one*:

<input checked="" type="checkbox"/>	<b>No.</b> The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
<input type="radio"/>	<b>Yes.</b> The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income as set forth in 42 CFR §447.52; (c) the groups of participants subject to cost-sharing and the groups who are excluded (groups of participants who are excluded must comply with 42 CFR §447.53); and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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# Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care ( <i>specify</i> ):							
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
			Total:			Total:	Difference
Year	Factor D	Factor D'	D+D'	Factor G	Factor G'	G+G'	(Column 7 less Column 4)
1	\$11,397.21	\$5,958.00	\$17,355.21	\$77,589.00	\$1,511.00	\$79,100.00	\$61,744.79
2	\$11,397.21	\$5,958.00	\$17,355.21	\$77,589.00	\$1,511.00	\$79,100.00	\$61,744.79
3	\$11,397.21	\$5,958.00	\$17,355.21	\$77,589.00	\$1,511.00	\$79,100.00	\$61,744.79
4	\$11,397.21	\$5,958.00	\$17,355.21	\$77,589.00	\$1,511.00	\$79,100.00	\$61,744.79
5	\$11,397.21	\$5,958.00	\$17,355.21	\$77,589.00	\$1,511.00	\$79,100.00	\$61,744.79

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## Appendix J-2 - Derivation of Estimates

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

<b>Table J-2-a: Unduplicated Participants</b>			
Waiver Year	Total Number Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	7793		
Year 2	7793		
Year 3	7793		
Year 4	7793		
Year 5	7793		

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

This estimate of the average length of stay by participants is based on the average of the historical utilization of annual units (days) of service authorized for use by participants. Average LOS is 292.

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

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

These estimates are based on three factors:

- Current rates schedules used in the MRWP and CHSS for waiver services
- Historical utilization of available funding by consumer
- Historical utilization of annual units of service authorized for use by consumer

- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

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

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- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

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

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

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

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

<input checked="" type="checkbox"/>	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
<input type="checkbox"/>	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

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

<b>NOW Waiver Year 1</b>					
<b>Waiver Service</b>	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	<b>Unit</b>	<b># Users</b>	<b>Avg. Units</b>	<b>Avg. Cost/</b>	<b>Total Cost</b>
			<b>Per User</b>	<b>Unit</b>	
Community Living Supports	15 Minutes	630	3072	2.88	\$5,573,836.80
Community Access	15 Minutes	4106	1152	6.35	\$30,036,211.20
Community Access Group	15 Minutes	2000	4608	2.43	\$22,394,880.00
Respite Services	15 Minutes	99	998	2.30	\$227,244.60
Respite Services Overnight	Daily	99	10	96.00	\$95,040.00
Supported Employment	15 Minutes	800	1152	6.35	\$5,852,160.00
Supported Employment Group	15 Minutes	125	3072	1.80	\$691,200.00
Prevocational Services	15 Minutes	600	4608	3.04	\$8,404,992.00
Natural Support Training Services	15 Minutes	786	68	17.89	\$956,184.72
Individual Directed Goods and Services	Item	450	16	75.00	\$540,000.00
Adult Occupational Therapy Services	Procedure	33	48	36.92	\$58,481.28
Adult Physical Therapy Services	Procedure	33	48	36.92	\$58,481.28
Adult Speech and Language Therapy Services	Procedure	34	48	36.92	\$60,253.44
Specialized Medical Equipment	Item	150	1	1,703.32	\$255,498.00
Specialized Medical Supplies	Item	440	7	62.50	\$192,500.00
Environmental Accessibility Adaptation	Item	100	1	4,996.82	\$499,682.00
Vehicle Adaptations	Item	50	1	3,120.00	\$156,000.00
Financial Support Services	Monthly	500	7	75.00	\$262,500.00
Support Coordination	Monthly	7793	7	149.88	\$8,176,103.88
Community Guide	15 Minutes	500	134	7.59	\$508,530.00
Behavioral Supports Consultation	15 Minutes	1000	62	21.16	\$1,311,920.00
Transportation	One Way Trip	5000	40	10.07	\$2,014,000.00
Adult Dental	Procedure	2500	5	39.42	\$492,750.00
<b>GRAND TOTAL:</b>					<b>\$88,818,449.20</b>
<b>TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)</b>					<b>7793</b>
<b>FACTOR D (Divide grand total by number of participants)</b>					<b>\$11,397.21</b>
<b>AVERAGE LENGTH OF STAY ON THE WAIVER</b>					<b>292</b>

State:	Georgia
Effective Date	October 1, 2007

<b>NOW Waiver Year 2</b>					
<b>Waiver Service</b>	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	<b>Unit</b>	<b># Users</b>	<b>Avg. Units</b>	<b>Avg. Cost/</b>	<b>Total Cost</b>
			<b>Per User</b>	<b>Unit</b>	
Community Living Supports	15 Minutes	630	3072	2.88	\$5,573,836.80
Community Access	15 Minutes	4106	1152	6.35	\$30,036,211.20
Community Access Group	15 Minutes	2000	4608	2.43	\$22,394,880.00
Respite Services	15 Minutes	99	998	2.30	\$227,244.60
Respite Services Overnight	Daily	99	10	96.00	\$95,040.00
Supported Employment	15 Minutes	800	1152	6.35	\$5,852,160.00
Supported Employment Group	15 Minutes	125	3072	1.80	\$691,200.00
Prevocational Services	15 Minutes	600	4608	3.04	\$8,404,992.00
Natural Support Training Services	15 Minutes	786	68	17.89	\$956,184.72
Individual Directed Goods and Services	Item	450	16	75.00	\$540,000.00
Adult Occupational Therapy Services	Procedure	33	48	36.92	\$58,481.28
Adult Physical Therapy Services	Procedure	33	48	36.92	\$58,481.28
Adult Speech and Language Therapy Services	Procedure	34	48	36.92	\$60,253.44
Specialized Medical Equipment	Item	150	1	1,703.32	\$255,498.00
Specialized Medical Supplies	Item	440	7	62.50	\$192,500.00
Environmental Accessibility Adaptation	Item	100	1	4,996.82	\$499,682.00
Vehicle Adaptations	Item	50	1	3,120.00	\$156,000.00
Financial Support Services	Monthly	500	7	75.00	\$262,500.00
Support Coordination	Monthly	7793	7	149.88	\$8,176,103.88
Community Guide	15 Minutes	500	134	7.59	\$508,530.00
Behavioral Supports Consultation	15 Minutes	1000	62	21.16	\$1,311,920.00
Transportation	One Way Trip	5000	40	10.07	\$2,014,000.00
Adult Dental	Procedure	2500	5	39.42	\$492,750.00
<b>GRAND TOTAL:</b>					<b>\$88,818,449.20</b>
<b>TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)</b>					<b>7793</b>
<b>FACTOR D (Divide grand total by number of participants)</b>					<b>\$11,397.21</b>
<b>AVERAGE LENGTH OF STAY ON THE WAIVER</b>					<b>292</b>

State:	Georgia
Effective Date	October 1, 2007

<b>NOW Waiver Year 3</b>					
<b>Waiver Service</b>	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	<b>Unit</b>	<b># Users</b>	<b>Avg. Units</b>	<b>Avg. Cost/</b>	<b>Total Cost</b>
			<b>Per User</b>	<b>Unit</b>	
Community Living Supports	15 Minutes	630	3072	2.88	\$5,573,836.80
Community Access	15 Minutes	4106	1152	6.35	\$30,036,211.20
Community Access Group	15 Minutes	2000	4608	2.43	\$22,394,880.00
Respite Services	15 Minutes	99	998	2.30	\$227,244.60
Respite Services Overnight	Daily	99	10	96.00	\$95,040.00
Supported Employment	15 Minutes	800	1152	6.35	\$5,852,160.00
Supported Employment Group	15 Minutes	125	3072	1.80	\$691,200.00
Prevocational Services	15 Minutes	600	4608	3.04	\$8,404,992.00
Natural Support Training Services	15 Minutes	786	68	17.89	\$956,184.72
Individual Directed Goods and Services	Item	450	16	75.00	\$540,000.00
Adult Occupational Therapy Services	Procedure	33	48	36.92	\$58,481.28
Adult Physical Therapy Services	Procedure	33	48	36.92	\$58,481.28
Adult Speech and Language Therapy Services	Procedure	34	48	36.92	\$60,253.44
Specialized Medical Equipment	Item	150	1	1,703.32	\$255,498.00
Specialized Medical Supplies	Item	440	7	62.50	\$192,500.00
Environmental Accessibility Adaptation	Item	100	1	4,996.82	\$499,682.00
Vehicle Adaptations	Item	50	1	3,120.00	\$156,000.00
Financial Support Services	Monthly	500	7	75.00	\$262,500.00
Support Coordination	Monthly	7793	7	149.88	\$8,176,103.88
Community Guide	15 Minutes	500	134	7.59	\$508,530.00
Behavioral Supports Consultation	15 Minutes	1000	62	21.16	\$1,311,920.00
Transportation	One Way Trip	5000	40	10.07	\$2,014,000.00
Adult Dental	Procedure	2500	5	39.42	\$492,750.00
<b>GRAND TOTAL:</b>					<b>\$88,818,449.20</b>
<b>TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)</b>					<b>7793</b>
<b>FACTOR D (Divide grand total by number of participants)</b>					<b>\$11,397.21</b>
<b>AVERAGE LENGTH OF STAY ON THE WAIVER</b>					<b>292</b>

State:	Georgia
Effective Date	October 1, 2007

<b>NOW Waiver Year 4</b>					
<b>Waiver Service</b>	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	<b>Unit</b>	<b># Users</b>	<b>Avg. Units</b>	<b>Avg. Cost/</b>	<b>Total Cost</b>
			<b>Per User</b>	<b>Unit</b>	
Community Living Supports	15 Minutes	630	3072	2.88	\$5,573,836.80
Community Access	15 Minutes	4106	1152	6.35	\$30,036,211.20
Community Access Group	15 Minutes	2000	4608	2.43	\$22,394,880.00
Respite Services	15 Minutes	99	998	2.30	\$227,244.60
Respite Services Overnight	Daily	99	10	96.00	\$95,040.00
Supported Employment	15 Minutes	800	1152	6.35	\$5,852,160.00
Supported Employment Group	15 Minutes	125	3072	1.80	\$691,200.00
Prevocational Services	15 Minutes	600	4608	3.04	\$8,404,992.00
Natural Support Training Services	15 Minutes	786	68	17.89	\$956,184.72
Individual Directed Goods and Services	Item	450	16	75.00	\$540,000.00
Adult Occupational Therapy Services	Procedure	33	48	36.92	\$58,481.28
Adult Physical Therapy Services	Procedure	33	48	36.92	\$58,481.28
Adult Speech and Language Therapy Services	Procedure	34	48	36.92	\$60,253.44
Specialized Medical Equipment	Item	150	1	1,703.32	\$255,498.00
Specialized Medical Supplies	Item	440	7	62.50	\$192,500.00
Environmental Accessibility Adaptation	Item	100	1	4,996.82	\$499,682.00
Vehicle Adaptations	Item	50	1	3,120.00	\$156,000.00
Financial Support Services	Monthly	500	7	75.00	\$262,500.00
Support Coordination	Monthly	7793	7	149.88	\$8,176,103.88
Community Guide	15 Minutes	500	134	7.59	\$508,530.00
Behavioral Supports Consultation	15 Minutes	1000	62	21.16	\$1,311,920.00
Transportation	One Way Trip	5000	40	10.07	\$2,014,000.00
Adult Dental	Procedure	2500	5	39.42	\$492,750.00
<b>GRAND TOTAL:</b>					<b>\$88,818,449.20</b>
<b>TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)</b>					<b>7793</b>
<b>FACTOR D (Divide grand total by number of participants)</b>					<b>\$11,397.21</b>
<b>AVERAGE LENGTH OF STAY ON THE WAIVER</b>					<b>292</b>

State:	Georgia
Effective Date	October 1, 2007

<b>NOW Waiver Year 5</b>					
<b>Waiver Service</b>	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	<b>Unit</b>	<b># Users</b>	<b>Avg. Units</b>	<b>Avg. Cost/</b>	<b>Total Cost</b>
			<b>Per User</b>	<b>Unit</b>	
Community Living Supports	15 Minutes	630	3072	2.88	\$5,573,836.80
Community Access	15 Minutes	4106	1152	6.35	\$30,036,211.20
Community Access Group	15 Minutes	2000	4608	2.43	\$22,394,880.00
Respite Services	15 Minutes	99	998	2.30	\$227,244.60
Respite Services Overnight	Daily	99	10	96.00	\$95,040.00
Supported Employment	15 Minutes	800	1152	6.35	\$5,852,160.00
Supported Employment Group	15 Minutes	125	3072	1.80	\$691,200.00
Prevocational Services	15 Minutes	600	4608	3.04	\$8,404,992.00
Natural Support Training Services	15 Minutes	786	68	17.89	\$956,184.72
Individual Directed Goods and Services	Item	450	16	75.00	\$540,000.00
Adult Occupational Therapy Services	Procedure	33	48	36.92	\$58,481.28
Adult Physical Therapy Services	Procedure	33	48	36.92	\$58,481.28
Adult Speech and Language Therapy Services	Procedure	34	48	36.92	\$60,253.44
Specialized Medical Equipment	Item	150	1	1,703.32	\$255,498.00
Specialized Medical Supplies	Item	440	7	62.50	\$192,500.00
Environmental Accessibility Adaptation	Item	100	1	4,996.82	\$499,682.00
Vehicle Adaptations	Item	50	1	3,120.00	\$156,000.00
Financial Support Services	Monthly	500	7	75.00	\$262,500.00
Support Coordination	Monthly	7793	7	149.88	\$8,176,103.88
Community Guide	15 Minutes	500	134	7.59	\$508,530.00
Behavioral Supports Consultation	15 Minutes	1000	62	21.16	\$1,311,920.00
Transportation	One Way Trip	5000	40	10.07	\$2,014,000.00
Adult Dental	Procedure	2500	5	39.42	\$492,750.00
<b>GRAND TOTAL:</b>					<b>\$88,818,449.20</b>
<b>TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)</b>					<b>7793</b>
<b>FACTOR D (Divide grand total by number of participants)</b>					<b>\$11,397.21</b>
<b>AVERAGE LENGTH OF STAY ON THE WAIVER</b>					<b>292</b>

State:	Georgia
Effective Date	October 1, 2007