

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

### 1. Major Changes

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

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

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

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

C. **Type of Request: renewal**

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

**3 years      5 years**

**Original Base Waiver Number: NV.4150**

**Waiver Number: NV.4150.R05.00**

**Draft ID:              NV.003.05.00**

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

Regular Waiver

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

**Approved Effective Date: 01/01/13**

### 1. Request Information (2 of 3)

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

**Hospital**

Select applicable level of care

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

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

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

**Nursing Facility**

Select applicable level of care

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

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

**Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140  
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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

## 1. Request Information (3 of 3)

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

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

**§1915(b)(2) (central broker)**

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

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

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

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

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

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

**A program authorized under §1115 of the Act.**

Specify the program:

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

Check if applicable:

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

## 2. Brief Waiver Description

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

### 3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
 

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

**No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

### 4. Waiver(s) Requested

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

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

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

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

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

## 5. Assurances

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

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

- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR 440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR 440.160.

## 6. Additional Requirements

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

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

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

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

## 7. Contact Person(s)

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:**

**Nevada**

**Zip:**

**Phone:**

**Ext:**

**TTY**

**Fax:**

**E-mail:**

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:**

**Nevada**

**Zip:**

**Phone:**

**Ext:**

**TTY**

**Fax:**

**E-mail:**

## 8. Authorizing Signature

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

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

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**Signature:**

State Medicaid Director or Designee

**Submission Date:**

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

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**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:**  
**Nevada**  
**Zip:**

**Phone:**

**Ext:**

**TTY**

**Fax:**

**E-mail:**

## **Attachments**

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### **Attachment #1: Transition Plan**

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

**Replacing an approved waiver with this waiver.**

**Combining waivers.**

**Splitting one waiver into two waivers.**

**Eliminating a service.**

**Adding or decreasing an individual cost limit pertaining to eligibility.**

**Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

**Reducing the unduplicated count of participants (Factor C).**

**Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

**Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**

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

Specify the transition plan for the waiver:

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

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

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

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

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

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

## **Additional Needed Information (Optional)**

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Provide additional needed information for the waiver (optional):

## **Appendix A: Waiver Administration and Operation**

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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*):

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

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

**The Medical Assistance Unit.**

Specify the unit name:

*(Do not complete item A-2)*

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

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

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

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

Specify the division/unit name:

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

## Appendix A: Waiver Administration and Operation

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### 2. Oversight of Performance.

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

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

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

**As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.**

## Appendix A: Waiver Administration and Operation

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

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

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

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

## Appendix A: Waiver Administration and Operation

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

**Not applicable**

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

Check each that applies:

**Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level.

There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth

responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

## Appendix A: Waiver Administration and Operation

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

## Appendix A: Waiver Administration and Operation

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

## Appendix A: Waiver Administration and Operation

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

| Function  | Medicaid Agency | Contracted Entity |
|---|-----------------|-------------------|
| Participant waiver enrollment                       |                 |                   |
| Waiver enrollment managed against approved limits   |                 |                   |
| Waiver expenditures managed against approved levels |                 |                   |
| Level of care evaluation                            |                 |                   |
| Review of Participant service plans                 |                 |                   |
| Prior authorization of waiver services              |                 |                   |
| Utilization management                              |                 |                   |
| Qualified provider enrollment                       |                 |                   |
| Execution of Medicaid provider agreements           |                 |                   |
| Establishment of a statewide rate methodology       |                 |                   |

|  |  |  |
|--|--|--|
| Rules, policies, procedures and information development governing the waiver program |  |  |
| Quality assurance and quality improvement activities                                 |  |  |

## Appendix A: Waiver Administration and Operation

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

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

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

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

**i. Performance Measures**

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

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

*Where possible, include numerator/denominator.*

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

**Performance Measure:**

**PM: Number and percent of qualified providers enrolled. Numerator: Number of providers enrolled.**

**Denominator: Number of providers who apply.**

**Data Source (Select one):**

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

If 'Other' is selected, specify:

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

|  |                                  |  |
|--|----------------------------------|--|
|  |                                  |  |
|  | <p><b>Other</b><br/>Specify:</p> |  |

**Data Aggregation and Analysis:**

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

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

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

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

**ii. Remediation Data Aggregation**

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

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

|  |                                 |
|--|---------------------------------|
|  | <b>Continuously and Ongoing</b> |
|  | <b>Other</b><br>Specify:        |

**c. Timelines**

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

**No**

**Yes**

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

**Appendix B: Participant Access and Eligibility**

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

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

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

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

**c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may

be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

**Not applicable. There is no maximum age limit**

**The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

## Appendix B: Participant Access and Eligibility

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

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

**No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage:

**Other**

*Specify:*

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

**Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

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

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

**The following dollar amount:**

Specify dollar amount:

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

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

Specify the formula:

**May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

**The following percentage that is less than 100% of the institutional average:**

Specify percent:

**Other:**

*Specify:*

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

**Other safeguard(s)**

Specify:

## Appendix B: Participant Access and Eligibility

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

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

**Table: B-3-a**

| Waiver Year | Unduplicated Number of Participants |
|-------------|-------------------------------------|
|-------------|-------------------------------------|

|        |  |
|--------|--|
| Year 1 |  |
| Year 2 |  |
| Year 3 |  |
| Year 4 |  |
| Year 5 |  |

**b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

**The State does not limit the number of participants that it serves at any point in time during a waiver year.**

**The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

**Table: B-3-b**

| Waiver Year | Maximum Number of Participants Served At Any Point During the Year |
|-------------|--|
| Year 1      |  |
| Year 2      |  |
| Year 3      |  |
| Year 4      |  |
| Year 5      |  |

## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

**The waiver is not subject to a phase-in or a phase-out schedule.**

**The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

**e. Allocation of Waiver Capacity.**

*Select one:*

**Waiver capacity is allocated/managed on a statewide basis.**

**Waiver capacity is allocated to local/regional non-state entities.**

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

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

---

## Appendix B: Participant Access and Eligibility

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

---

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

---

## Appendix B: Participant Access and Eligibility

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

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

§1634 State

SSI Criteria State

209(b) State

**2. Miller Trust State.**

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

No

Yes

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

---

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

---

Low income families with children as provided in §1931 of the Act

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

Optional State supplement recipients

Optional categorically needy aged and/or disabled individuals who have income at:

*Select one:*

100% of the Federal poverty level (FPL)

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

Specify percentage:

Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii) (XIII) of the Act)

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

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

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

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

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

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

*Specify:*

---

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

---

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

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

*Select one and complete Appendix B-5.*

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

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

*Check each that applies:*

**A special income level equal to:**

*Select one:*

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

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

*Specify percentage:*

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

*Specify dollar amount:*

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

**Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

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

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

*Select one:*

**100% of FPL**

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

*Specify percentage amount:*

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

*Specify:*

## Appendix B: Participant Access and Eligibility

---

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

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

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

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

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

*Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

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

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

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

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

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

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

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

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

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

## Appendix B: Participant Access and Eligibility

---

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

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

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

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

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

**The following standard included under the State plan**

*Select one:*

**SSI standard**

**Optional State supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

*(select one):*

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

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

Specify the percentage:

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

Specify dollar amount:

**A percentage of the Federal poverty level**

Specify percentage:

**Other standard included under the State Plan**

*Specify:*

**The following dollar amount**

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

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

*Specify:*

**Other**

*Specify:*

---

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

---

**Not Applicable**

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

*Specify:*

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

**SSI standard**

**Optional State supplement standard**

**Medically needy income standard**

**The following dollar amount:**

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

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

*Specify:*

---

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

---

**Not Applicable (see instructions)**

**AFDC need standard**

**Medically needy income standard**

**The following dollar amount:**

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

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

*Specify:*

**Other**

*Specify:*

---

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

---

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

Select one:

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

**The State does not establish reasonable limits.**

**The State establishes the following reasonable limits**

*Specify:*

---

## Appendix B: Participant Access and Eligibility

---

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

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

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

---

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

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---

## Appendix B: Participant Access and Eligibility

---

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

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

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

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

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

*(select one):*

**SSI standard**

**Optional State supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

**A percentage of the Federal poverty level**

Specify percentage:

**The following dollar amount:**

Specify dollar amount:

If this amount changes, this item will be revised

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

*Specify formula:*

**Other**

*Specify:*

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

Select one:

**Allowance is the same**

**Allowance is different.**

*Explanation of difference:*

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

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

Select one:

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

**The State does not establish reasonable limits.**

**The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

## Appendix B: Participant Access and Eligibility

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

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

**e. Regular Post-Eligibility Treatment of Income: SSI State - 2014 through 2018.**

---

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

---

## Appendix B: Participant Access and Eligibility

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

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

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

---

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

---

## Appendix B: Participant Access and Eligibility

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

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

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

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

---

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

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## Appendix B: Participant Access and Eligibility

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

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

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

**i. Minimum number of services.**

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

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

**The provision of waiver services at least monthly**

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

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

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

**Directly by the Medicaid agency**

**By the operating agency specified in Appendix A**

**By an entity under contract with the Medicaid agency.**

*Specify the entity:*

**Other**

*Specify:*

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

**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.

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

**The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**

**A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

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

**Every three months**

**Every six months**

**Every twelve months**

**Other schedule**

*Specify the other schedule:*

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

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

**The qualifications are different.**

*Specify the qualifications:*

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

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

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

### Quality Improvement: Level of Care

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

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of new applicants who meet Level of Care prior to receiving services.**

**Numerator: Number of new applicants who meet Level of Care prior to receiving services.**

**Denominator: Number of new applicants.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

|   |  |  |
|---|--|--|
| <b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ): | <b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ): | <b>Sampling Approach</b> ( <i>check each that applies</i> ): |
|---|--|--|

|                              |                                 |   |
|------------------------------|---------------------------------|---|
| <b>State Medicaid Agency</b> | <b>Weekly</b>                   | <b>100% Review</b>                                    |
| <b>Operating Agency</b>      | <b>Monthly</b>                  | <b>Less than 100% Review</b>                          |
| <b>Sub-State Entity</b>      | <b>Quarterly</b>                | <b>Representative Sample</b><br>Confidence Interval = |
| <b>Other</b><br>Specify:     | <b>Annually</b>                 | <b>Stratified</b><br>Describe Group:                  |
|                              | <b>Continuously and Ongoing</b> | <b>Other</b><br>Specify:                              |
|                              | <b>Other</b><br>Specify:        |   |

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Intake Packet Reviews - DHCFP Central Office**

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

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of recipients whose Level of Care was reevaluated annually. Numerator: Number of recipients whose Level of Care was reevaluated annually. Denominator: Number of recipients reviewed.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

|  |                                 |                          |
|--|---------------------------------|--------------------------|
|  |                                 |                          |
|  | <b>Continuously and Ongoing</b> | <b>Other</b><br>Specify: |
|  | <b>Other</b><br>Specify:        |                          |

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of recipients whose Level of Care eligibility was accurately determined.**

**Numerator:** Number of recipients whose Level of Care eligibility was accurately determined.

**Denominator:** Number of recipients reviewed.

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

|  |  |  |
|--|--|--|
|  |  |  |
|--|--|--|

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of recipients whose Level of Care eligibility determinations were based on accurate application of policy. Numerator: Number of recipients whose Level of Care eligibility determinations were based on accurate application of policy; Denominator: Number of recipients reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

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

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

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

**ii. Remediation Data Aggregation**

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

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

**c. Timelines**

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

**No**

**Yes**

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

**Appendix B: Participant Access and Eligibility**

**B-7: Freedom of Choice**

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

## Appendix C: Participant Services

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

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

| Service Type                | Service                                    |  |  |
|-----------------------------|--|---|---|
| Statutory Service           | Case Management                            |   |   |
| Statutory Service           | Homemaker                                  |   |   |
| Statutory Service           | Respite                                    |   |   |
| Extended State Plan Service | Attendant Care Services                    |   |   |
| Extended State Plan Service | Specialized Medical Equipment and Supplies |   |   |
| Other Service               | Assisted Living Services                   |   |   |
| Other Service               | Chore Services                             |   |   |
| Other Service               | Environmental Accessibility Adaptations    |   |   |
| Other Service               | Home Delivered Meals                       |   |   |
| Other Service               | Personal Emergency Response Systems (PERS) |   |   |

## Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Case Management

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

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

**Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

| <b>Provider Category</b> | <b>Provider Type Title</b>                                  |
|--------------------------|---|
| <b>Agency</b>            | <b>Case Management Provider Agency</b>                      |
| <b>Agency</b>            | <b>Division of Health Care Financing and Policy (DHCFP)</b> |

## **Appendix C: Participant Services**

---

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

---

**Service Type: Statutory Service**  
**Service Name: Case Management**

---

**Provider Category:**

Agency

**Provider Type:**

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

## Appendix C: Participant Services

---

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

---

**Service Type: Statutory Service**  
**Service Name: Case Management**

---

**Provider Category:**

Agency

**Provider Type:**

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

**Appendix C: Participant Services**

---

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

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

**Service Type:**

Statutory Service

**Service:**

Homemaker

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

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title  |
|-------------------|--|
| Individual        | Individual Provider  |
| Agency            | Homemaker Provider Agency or Personal Care Services Agency |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Homemaker**

**Provider Category:**

Individual

**Provider Type:**

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

**Appendix C: Participant Services**

---

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

---

**Service Type: Statutory Service**

**Service Name: Homemaker**

---

**Provider Category:**

Agency

**Provider Type:**

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

**Appendix C: Participant Services**

---

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

---

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

**Service Type:**

Statutory Service

**Service:**

Respite

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

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

**Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

|  |
|--|
|  |
|--|

| Provider Category | Provider Type Title                                      |
|-------------------|--|
| Individual        | Individual Respite Provider                              |
| Agency            | Respite Provider Agency or Personal Care Services Agency |

## Appendix C: Participant Services

---

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

---

**Service Type: Statutory Service**

**Service Name: Respite**

---

**Provider Category:**

Individual

**Provider Type:**

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

## Appendix C: Participant Services

---

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

---

**Service Type: Statutory Service**

**Service Name: Respite**

---

**Provider Category:**

Agency

**Provider Type:**

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

**Appendix C: Participant Services**

---

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

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

**Service Type:**

Extended State Plan Service

**Service Title:**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title                          |
|-------------------|--|
| Agency            | Personal Care Services (PCS) Provider Agency |
| Agency            | Intermediary Service Organization (ISO)      |

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**

**Service Name: Attendant Care Services**

**Provider Category:**

Agency

**Provider Type:**

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

## Appendix C: Participant Services

---

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

---

**Service Type: Extended State Plan Service**

**Service Name: Attendant Care Services**

---

**Provider Category:**

Agency

**Provider Type:**

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

## Appendix C: Participant Services

---

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

---

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

**Service Type:**

Extended State Plan Service

**Service Title:**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

**Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

---

|                          |   |
|--------------------------|---|
| <b>Provider Category</b> | <b>Provider Type Title</b>  |
| Agency                   | Durable Medical Equipment, Prosthetic Devices, Orthotic Devices, and Disposable Medical Supplies (DMEPOS) Provider Agency |

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**

**Service Name: Specialized Medical Equipment and Supplies**

**Provider Category:**

Agency

**Provider Type:**

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

**Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title      |
|-------------------|--------------------------|
| Agency            | Assisted Living Provider |

## Appendix C: Participant Services

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

---

**Service Type: Other Service**

**Service Name: Assisted Living Services**

---

**Provider Category:**

Agency

**Provider Type:**

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

**Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title            |
|-------------------|--------------------------------|
| Agency            | Chore Services Provider Agency |

## Appendix C: Participant Services

---

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

---

**Service Type: Other Service**  
**Service Name: Chore Services**

---

**Provider Category:**

Agency

**Provider Type:**

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

---

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title                              |
|-------------------|--|
| Agency            | Environmental Accessibility Adaptations Provider |

## Appendix C: Participant Services

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

---

**Service Type: Other Service**

**Service Name: Environmental Accessibility Adaptations**

---

**Provider Category:**

Agency

**Provider Type:**

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

**Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title             |
|-------------------|---------------------------------|
| Agency            | Agency for Home Delivered Meals |

## **Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Home Delivered Meals**

**Provider Category:**

Agency

**Provider Type:**

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

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

**Service Title:**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

**Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title  |
|-------------------|----------------------|
| Agency            | PERS Provider Agency |

**Appendix C: Participant Services**

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

---

**Service Type: Other Service**

**Service Name: Personal Emergency Response Systems (PERS)**

---

**Provider Category:**

Agency

**Provider Type:**

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

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

**Frequency of Verification:**

## Appendix C: Participant Services

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

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

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

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

*Check each that applies:*

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

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

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

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

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

## Appendix C: Participant Services

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### C-2: General Service Specifications (1 of 3)

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

**No. Criminal history and/or background investigations are not required.**

**Yes. Criminal history and/or background investigations are required.**

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

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

**No. The State does not conduct abuse registry screening.**

**Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

## Appendix C: Participant Services

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### C-2: General Service Specifications (2 of 3)

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

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

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

## Appendix C: Participant Services

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### C-2: General Service Specifications (3 of 3)

- d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

**No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**

**Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

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

**The State does not make payment to relatives/legal guardians for furnishing waiver services.**

**The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

**Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

**Other policy.**

Specify:

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

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

---

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

#### **a. Methods for Discovery: Qualified Providers**

*The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*

##### **i. Sub-Assurances:**

**a. Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

##### **Performance Measures**

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

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

##### **Performance Measure:**

**Number and percent of provider applicants that meet licensure/certification qualifications prior to delivering services. Numerator: Number of provider applicants that meet licensure/certification qualifications prior to delivering services; Denominator: Total number of provider applicants.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Provider Enrollment Report**

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of currently enrolled providers, by type, that continue to meet licensure/certification qualifications. Numerator: Number of currently enrolled providers, by type, that continue to meet licensure/certification qualifications; Denominator: Total number of currently**

**enrolled providers.****Data Source** (Select one):**Provider performance monitoring**

If 'Other' is selected, specify:

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

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**Provider Re-enrollment Report**

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

|  |                                  |  |
|--|----------------------------------|--|
|  |                                  |  |
|  | <p><b>Other</b><br/>Specify:</p> |  |

**Data Aggregation and Analysis:**

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

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

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

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

**Performance Measure:**

**Number and percent of non-licensed/non-certified provider applicants that meet qualifications prior to delivering services. Numerator: Number of non-licensed/non-certified provider applicants that meet qualifications prior to delivering services; Denominator: Total number of non-licensed/non-certified provider applicants.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Provider Enrollment Report**

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

|                          |                                 |   |
|--------------------------|---------------------------------|---|
| <b>Sub-State Entity</b>  | <b>Quarterly</b>                | <b>Representative Sample</b><br>Confidence Interval = |
| <b>Other</b><br>Specify: | <b>Annually</b>                 | <b>Stratified</b><br>Describe Group:                  |
|                          | <b>Continuously and Ongoing</b> | <b>Other</b><br>Specify:                              |
|                          | <b>Other</b><br>Specify:        |   |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of currently enrolled non-licensed/non-certified providers that continue to meet qualifications. Numerator: Number of currently enrolled non-licensed/non-certified providers that continue to meet qualifications; Denominator: Total number of currently enrolled non-licensed/non-certified providers.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Provider Re-enrollment Report**

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

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

**Data Aggregation and Analysis:**

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

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

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

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

**Performance Measure:**

**Number and percent of agencies whose employees receive required training prior to delivering services. Numerator: Number of agencies whose employees receive training prior to delivering services; Denominator: Number of agencies reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Provider On Site Review**

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

**Data Aggregation and Analysis:**

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

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

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

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

**ii. Remediation Data Aggregation**

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

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

**c. Timelines**

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

**No**

**Yes**

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

**Appendix C: Participant Services**

**C-3: Waiver Services Specifications**

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

**Appendix C: Participant Services**

**C-4: Additional Limits on Amount of Waiver Services**

- a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

**Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

**Applicable -** The State imposes additional limits on the amount of waiver services.

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

**Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

*Furnish the information specified above.*

**Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

*Furnish the information specified above.*

**Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

*Furnish the information specified above.*

**Other Type of Limit.** The State employs another type of limit.

*Describe the limit and furnish the information specified above.*

## Appendix C: Participant Services

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### C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

*Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (1 of 8)

**State Participant-Centered Service Plan Title:**

- a. **Responsibility for Service Plan Development.** Per 42 CFR 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

**Registered nurse, licensed to practice in the State**

**Licensed practical or vocational nurse, acting within the scope of practice under State law**

**Licensed physician (M.D. or D.O)**

**Case Manager** (qualifications specified in Appendix C-1/C-3)

**Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

**Social Worker**

*Specify qualifications:*

**Other**

*Specify the individuals and their qualifications:*

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (2 of 8)

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

**Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (3 of 8)

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

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (4 of 8)

- d. **Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan,

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

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (5 of 8)

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

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (6 of 8)

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

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (7 of 8)

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

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (8 of 8)

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

**Every three months or more frequently when necessary**

**Every six months or more frequently when necessary**

**Every twelve months or more frequently when necessary**

**Other schedule**

*Specify the other schedule:*

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR 92.42. Service plans are maintained by the following (*check each that applies*):

**Medicaid agency**

**Operating agency**

**Case manager**

**Other**

*Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

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### 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.

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

**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

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### Quality Improvement: Service Plan

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

- a. Methods for Discovery: Service Plan Assurance/Sub-assurances**

*The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*

- i. Sub-Assurances:**

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

**Performance Measures**

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

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

**Performance Measure:**

**PM: Number and percent of recipients POCs that address the assessed needs identified in the social health assessment. N: Number of recipients POCs that address the assessed needs identified in the social health assessment; D: Number of recipient POCs reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**PM: Number and percent of recipients POCs that address health and safety risk factors identified in the social health assessment. N: Number of recipients POCs that address health and safety risk factors identified in the social health assessment; D: Number of recipient POCs reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**PM: Number and percent of recipients POCs that address personal goals identified in the social/health assessment. N: Number of recipients POCs that address personal goals identified in the social/health assessment; D: Number of recipient POCs reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

**Performance Measure:**

**PM: Number and percent of recipients POCs that contain the recipients signature indicating participation in POC development. N: Number of recipients POCs that contain the recipients signature indicating participation in POC development; D: Number of recipients POCs reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

| <b>Responsible Party for data aggregation and analysis</b> (check each that applies): | <b>Frequency of data aggregation and analysis</b> (check each that applies): |
|---|--|
| <b>State Medicaid Agency</b>  | <b>Weekly</b>  |
| <b>Operating Agency</b>   | <b>Monthly</b>   |
| <b>Sub-State Entity</b>   | <b>Quarterly</b>   |
|   |  |

|                          |                                 |
|--------------------------|---------------------------------|
| <b>Other</b><br>Specify: | <b>Annually</b>                 |
|                          | <b>Continuously and Ongoing</b> |
|                          | <b>Other</b><br>Specify:        |

**Performance Measure:**

**PM: Number and percent of new applicants whose POC is completed within no more than 30 calendar days of waiver enrollment. N: Number of new applicants whose POC is completed within no more than 30 calendar days of waiver enrollment; D: Number of recipients POCs reviewed.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

| <b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i> | <b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i> |
|--|---|
| <b>State Medicaid Agency</b>   | <b>Weekly</b>   |
| <b>Operating Agency</b>  | <b>Monthly</b>  |
| <b>Sub-State Entity</b>  | <b>Quarterly</b>  |

|                          |                                 |
|--------------------------|---------------------------------|
| <b>Other</b><br>Specify: | <b>Annually</b>                 |
|                          | <b>Continuously and Ongoing</b> |
|                          | <b>Other</b><br>Specify:        |

c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.*

**Performance Measures**

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

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

**Performance Measure:**

**PM: Number and percent of recipients POCs that are revised annually. N: Number of recipients POCs that are revised annually. D: Number of recipients POCs reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

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|--|--|--|

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**PM:** Number and percent of recipients POCs that are updated when the participants needs changed.

**N:** Number of recipients POCs that are updated when the participants needs changed. **D:** Number of recipients POCs reviewed where there was a documented change in need.

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

|  |  |  |
|--|--|--|
|  |  |  |
|--|--|--|

**Data Aggregation and Analysis:**

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

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

**Performance Measures**

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

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

**Performance Measure:**

**PM:** Number and percent of recipients services that are delivered in accordance with the approved POC. **N:** Number of recipients whose services are delivered in accordance with the approved POC.

**D:** Number of recipients records reviewed.

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

|                          |                                 |                                      |
|--------------------------|---------------------------------|--------------------------------------|
|                          |                                 |                                      |
| <b>Other</b><br>Specify: | <b>Annually</b>                 | <b>Stratified</b><br>Describe Group: |
|                          | <b>Continuously and Ongoing</b> | <b>Other</b><br>Specify:             |
|                          | <b>Other</b><br>Specify:        |                                      |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**PM:** Number and percent of recipients who indicate during monthly contacts that they are receiving the services they need. **N:** Number of recipients who indicate they are receiving the services they need. **D:** Number of recipients reviewed.

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

|                          |                                 |                                      |
|--------------------------|---------------------------------|--------------------------------------|
|                          |                                 |                                      |
| <b>Other</b><br>Specify: | <b>Annually</b>                 | <b>Stratified</b><br>Describe Group: |
|                          | <b>Continuously and Ongoing</b> | <b>Other</b><br>Specify:             |
|                          | <b>Other</b><br>Specify:        |                                      |

**Data Aggregation and Analysis:**

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

- e. **Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.**

**Performance Measures**

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

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

**Performance Measure:**

**PM: Number and percent of recipients whose SOU is signed indicating choice of waiver services and institutional care, choice of providers and choice of services. N: Number of recipients whose SOU is signed indicating choice of waiver services and institutional care, choice of providers and choice of**

**services. D: Number of recipient records reviewed.****Data Source** (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

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

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

If 'Other' is selected, specify:

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

|  |                          |  |
|--|--------------------------|--|
|  | <b>Other</b><br>Specify: |  |
|--|--------------------------|--|

**Data Aggregation and Analysis:**

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

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

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

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

**ii. Remediation Data Aggregation**

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

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

|  |                          |
|--|--------------------------|
|  | <b>Other</b><br>Specify: |
|--|--------------------------|

**c. Timelines**

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

**No**

**Yes**

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

**Appendix E: Participant Direction of Services**

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**Applicability** (from Application Section 3, Components of the Waiver Request):

**Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

**No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

**Indicate whether Independence Plus designation is requested** (select one):

**Yes. The State requests that this waiver be considered for Independence Plus designation.**

**No. Independence Plus designation is not requested.**

**Appendix E: Participant Direction of Services**

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**E-1: Overview (1 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (2 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (3 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (4 of 13)**

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (5 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (6 of 13)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (7 of 13)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (8 of 13)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (9 of 13)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (10 of 13)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (11 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (12 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (13 of 13)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-2: Opportunities for Participant Direction (1 of 6)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-2: Opportunities for Participant-Direction (2 of 6)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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## Appendix E: Participant Direction of Services

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### E-2: Opportunities for Participant-Direction (3 of 6)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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### E-2: Opportunities for Participant-Direction (4 of 6)

---

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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### E-2: Opportunities for Participant-Direction (5 of 6)

---

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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### E-2: Opportunities for Participant-Direction (6 of 6)

---

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix F: Participant Rights

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

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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.

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## Appendix F: Participant-Rights

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### Appendix F-2: Additional Dispute Resolution Process

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

**No. This Appendix does not apply**

**Yes. The State operates an additional dispute resolution process**

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

## Appendix F: Participant-Rights

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

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

**No. This Appendix does not apply**

**Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

**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).

## Appendix G: Participant Safeguards

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

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

**Yes. The State operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)

**No. This Appendix does not apply** (*do not complete Items b through e*)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

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

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

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

## Appendix G: Participant Safeguards

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### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

**The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

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### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

- b. Use of Restrictive Interventions.** *(Select one):*

**The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

**The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

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

- 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:

## Appendix G: Participant Safeguards

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### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. **Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

**The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

**The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
  
- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

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### Appendix G-3: Medication Management and Administration (1 of 2)

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

- a. **Applicability.** Select one:

**No. This Appendix is not applicable** *(do not complete the remaining items)*

**Yes. This Appendix applies** *(complete the remaining items)*

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

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

- 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.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

#### c. Medication Administration by Waiver Providers

**Answers provided in G-3-a indicate you do not need to complete this section**

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

**Not applicable.** *(do not complete the remaining items)*

**Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

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

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

**Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

*Complete the following three items:*

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the State:

**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

**iv. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers

in the administration of medications to waiver participants and how monitoring is performed and its frequency.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

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

**a. Methods for Discovery: Health and Welfare**

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**PM: Number and percent of recipients serious occurrences that were reported according to waiver and/or state policy. Numerator: Number of serious occurrences reported. Denominator: Number of serious occurrences that should have been reported as discovered after the fact.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

|  |                                  |  |
|--|----------------------------------|--|
|  |                                  |  |
|  | <p><b>Other</b><br/>Specify:</p> |  |

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Serious Occurrence Report**

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

**Data Aggregation and Analysis:**

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

|  |                          |
|--|--------------------------|
|  | <b>Other</b><br>Specify: |
|--|--------------------------|

**Performance Measure:**

**PM: Number and percent of recipients serious occurrence reports that include appropriate follow-up by the case manager. Numerator: Number of serious occurrences that received follow-up.**

**Demoninator: Number of serious occurrences requiring follow up.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Serious Occurrence Report**

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

|          |                                 |                          |
|----------|---------------------------------|--------------------------|
| Specify: |                                 | Describe Group:          |
|          | <b>Continuously and Ongoing</b> | <b>Other</b><br>Specify: |
|          | <b>Other</b><br>Specify:        |                          |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**PM: Number and percent of recipients serious occurrence reports that are reported within 24 hours of discovery. Numerator: Number of serious occurrence reports received within 24 hours.**

**Denominator: Number of serious occurrence reports received.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

|          |                                 |                          |
|----------|---------------------------------|--------------------------|
| Specify: |                                 | Describe Group:          |
|          | <b>Continuously and Ongoing</b> | <b>Other</b><br>Specify: |
|          | <b>Other</b><br>Specify:        |                          |

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Serious Occurrence Report**

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

**Data Aggregation and Analysis:**

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

|          |                                 |
|----------|---------------------------------|
| Specify: |                                 |
|          | <b>Continuously and Ongoing</b> |
|          | <b>Other</b><br>Specify:        |

**Performance Measure:**

**PM: Number and percent of recipients who received information about how to report A/N/E initially and every six months. Numerator: Total number of recipient who receive information on how to report A/N/E. Denominator: Total number of recipients.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

| Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ): | Frequency of data aggregation and analysis( <i>check each that applies</i> ): |
|---|---|
| <b>State Medicaid Agency</b>  | <b>Weekly</b>   |
| <b>Operating Agency</b>   | <b>Monthly</b>  |
| <b>Sub-State Entity</b>   | <b>Quarterly</b>  |

|                                  |  |
|----------------------------------|--|
| <p><b>Other</b><br/>Specify:</p> | <p><b>Annually</b></p>                 |
|                                  | <p><b>Continuously and Ongoing</b></p> |
|                                  | <p><b>Other</b><br/>Specify:</p>       |

- b. Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.**

**Performance Measures**

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

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

- c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

**Performance Measures**

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

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

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

**Performance Measures**

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

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

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

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

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

**ii. Remediation Data Aggregation**

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

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

**c. Timelines**

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

**No**

**Yes**

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

**Appendix H: Quality Improvement Strategy (1 of 2)**

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

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

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

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS

recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

**Quality Improvement Strategy: Minimum Components**

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

**Appendix H: Quality Improvement Strategy (2 of 2)**

**H-1: Systems Improvement**

**a. System Improvements**

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

**ii. System Improvement Activities**

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

**b. System Design Changes**

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's

targeted standards for systems improvement.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

## Appendix I: Financial Accountability

### I-1: Financial Integrity and Accountability

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

## Appendix I: Financial Accountability

### Quality Improvement: Financial Accountability

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

**a. Methods for Discovery: Financial Accountability**

*State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

**i. Sub-Assurances:**

- a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)**

**Performance Measures**

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

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

**Performance Measure:**

**PM: Number and percent of recipients claims that are coded and paid correctly in accordance with the service plan, daily record, and prior authorization. N: Number of recipients claims that are coded and paid correctly in accordance with the service plan, daily record, and prior authorization. D: Number of claims reviewed.**

**Data Source** (Select one):

**Financial records (including expenditures)**

If 'Other' is selected, specify:

|                                   |                          |                                 |
|-----------------------------------|--------------------------|---------------------------------|
| <b>Responsible Party for data</b> | <b>Frequency of data</b> | <b>Sampling Approach</b> (check |
|-----------------------------------|--------------------------|---------------------------------|

| <b>collection/generation</b> ( <i>check each that applies</i> ): | <b>collection/generation</b> ( <i>check each that applies</i> ): | <i>each that applies</i> :                            |
|--|--|---|
| <b>State Medicaid Agency</b>                                     | <b>Weekly</b>  | <b>100% Review</b>                                    |
| <b>Operating Agency</b>  | <b>Monthly</b>   | <b>Less than 100% Review</b>                          |
| <b>Sub-State Entity</b>  | <b>Quarterly</b>   | <b>Representative Sample</b><br>Confidence Interval = |
| <b>Other</b><br>Specify:   | <b>Annually</b>  | <b>Stratified</b><br>Describe Group:                  |
|  | <b>Continuously and Ongoing</b>                                  | <b>Other</b><br>Specify:                              |
|  | <b>Other</b><br>Specify:   |   |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**PM: Number and percent of recipients whose eligibility is verified prior to services being authorized.**  
**Numerator: Number of recipients whose eligibility is verified. Denominator: Number of recipients reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

| <b>Responsible Party for data</b> | <b>Frequency of data</b> | <b>Sampling Approach</b> ( <i>check</i> |
|-----------------------------------|--------------------------|---|
|-----------------------------------|--------------------------|---|

| <b>collection/generation</b> ( <i>check each that applies</i> ): | <b>collection/generation</b> ( <i>check each that applies</i> ): | <i>each that applies</i> :                            |
|--|--|---|
| <b>State Medicaid Agency</b>                                     | <b>Weekly</b>  | <b>100% Review</b>                                    |
| <b>Operating Agency</b>  | <b>Monthly</b>   | <b>Less than 100% Review</b>                          |
| <b>Sub-State Entity</b>  | <b>Quarterly</b>   | <b>Representative Sample</b><br>Confidence Interval = |
| <b>Other</b><br>Specify:   | <b>Annually</b>  | <b>Stratified</b><br>Describe Group:                  |
|  | <b>Continuously and Ongoing</b>                                  | <b>Other</b><br>Specify:                              |
|  | <b>Other</b><br>Specify:   |   |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**PM: The Medicaid Management Information System (MMIS) ensures that paid claims do not exceed the authorized limits on services for recipients. Numerator: Number of claims that did not exceed the authorized limit on services. Denominator: Number of claims reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

| <b>Responsible Party for data</b> | <b>Frequency of data</b> | <b>Sampling Approach</b> ( <i>check</i> |
|-----------------------------------|--------------------------|---|
|-----------------------------------|--------------------------|---|

| <b>collection/generation</b> ( <i>check each that applies</i> ): | <b>collection/generation</b> ( <i>check each that applies</i> ): | <i>each that applies</i> :                            |
|--|--|---|
| <b>State Medicaid Agency</b>                                     | <b>Weekly</b>  | <b>100% Review</b>                                    |
| <b>Operating Agency</b>  | <b>Monthly</b>   | <b>Less than 100% Review</b>                          |
| <b>Sub-State Entity</b>  | <b>Quarterly</b>   | <b>Representative Sample</b><br>Confidence Interval = |
| <b>Other</b><br>Specify:   | <b>Annually</b>  | <b>Stratified</b><br>Describe Group:                  |
|  | <b>Continuously and Ongoing</b>                                  | <b>Other</b><br>Specify:                              |
|  | <b>Other</b><br>Specify:   |   |

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

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

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

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

**ii. Remediation Data Aggregation**

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

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

**c. Timelines**

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

**No**

**Yes**

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

**Appendix I: Financial Accountability**

**I-2: Rates, Billing and Claims (1 of 3)**

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

operating agency (if applicable).

- 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:

## Appendix I: Financial Accountability

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### I-2: Rates, Billing and Claims (2 of 3)

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

**No. State or local government agencies do not certify expenditures for waiver services.**

**Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

*Select at least one:*

**Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)

**Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

## Appendix I: Financial Accountability

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### I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:
- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR 92.42.

## Appendix I: Financial Accountability

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### I-3: Payment (1 of 7)

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

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

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

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

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

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

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

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

## Appendix I: Financial Accountability

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### I-3: Payment (2 of 7)

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

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

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

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

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

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

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

## Appendix I: Financial Accountability

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### I-3: Payment (3 of 7)

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

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

**Yes. The State makes supplemental or enhanced payments for waiver services.**

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

## Appendix I: Financial Accountability

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### I-3: Payment (4 of 7)

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

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

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

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

## Appendix I: Financial Accountability

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### I-3: Payment (5 of 7)

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

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

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

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

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

Describe the recoupment process:

## Appendix I: Financial Accountability

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### I-3: Payment (6 of 7)

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

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

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

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

## Appendix I: Financial Accountability

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### I-3: Payment (7 of 7)

**g. Additional Payment Arrangements**

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

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

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

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

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

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

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

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

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

**The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

**The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

**This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

## Appendix I: Financial Accountability

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### I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

**Appropriation of State Tax Revenues to the State Medicaid agency**

**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

**Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

## Appendix I: Financial Accountability

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### I-4: Non-Federal Matching Funds (2 of 3)

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

**Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

**Applicable**

*Check each that applies:*

**Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

**Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to

transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

## Appendix I: Financial Accountability

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### I-4: Non-Federal Matching Funds (3 of 3)

- c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

**None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

**The following source(s) are used**

*Check each that applies:*

**Health care-related taxes or fees**

**Provider-related donations**

**Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

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

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

**No services under this waiver are furnished in residential settings other than the private residence of the individual.**

**As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

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

## Appendix I: Financial Accountability

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

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

**No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**

**Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in

personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

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### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

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

**No. The State does not impose a co-payment or similar charge upon participants for waiver services.**

**Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

**i. Co-Pay Arrangement.**

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

---

*Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

---

Nominal deductible

Coinsurance

Co-Payment

Other charge

*Specify:*

## Appendix I: Financial Accountability

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### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

- a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

---

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

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## Appendix I: Financial Accountability

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### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

- a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

---

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

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## Appendix I: Financial Accountability

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### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

- a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

---

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

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**Appendix I: Financial Accountability****I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)**

- b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

**No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**

**Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: Nursing Facility**

| Col. 1 | Col. 2   | Col. 3    | Col. 4      | Col. 5   | Col. 6    | Col. 7      | Col. 8                          |
|--------|----------|-----------|-------------|----------|-----------|-------------|---------------------------------|
| Year   | Factor D | Factor D' | Total: D+D' | Factor G | Factor G' | Total: G+G' | Difference (Col 7 less Column4) |
| 1      | 10387.11 |           | 35163.11    |          |           | 76902.00    | 41738.89                        |
| 2      | 10669.57 |           | 36287.57    |          |           | 79440.00    | 43152.43                        |
| 3      | 11044.72 |           | 37533.72    |          |           | 82061.00    | 44527.28                        |
| 4      | 11537.19 |           | 38927.19    |          |           | 84769.00    | 45841.81                        |
| 5      | 13979.54 |           | 42300.54    |          |           | 87566.00    | 45265.46                        |

**Appendix J: Cost Neutrality Demonstration****J-2: Derivation of Estimates (1 of 9)**

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

**Table: J-2-a: Unduplicated Participants**

| Waiver Year | Total Unduplicated Number of Participants<br>(from Item B-3-a) | Distribution of Unduplicated Participants by Level of Care<br>(if applicable) |
|-------------|--|---|
|             |  | Level of Care:<br>Nursing Facility  |
| Year 1      | 771  |   |
| Year 2      | 844  |   |
| Year 3      | 921  |   |
| Year 4      | 1010   |   |
| Year 5      | 1105   |   |

**Appendix J: Cost Neutrality Demonstration**

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

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

## Appendix J: Cost Neutrality Demonstration

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

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

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

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

| Waiver Services                            |  |
|--|---|
| Case Management                            |   |
| Homemaker                                  |   |
| Respite                                    |   |
| Attendant Care Services                    |   |
| Specialized Medical Equipment and Supplies |   |
| Assisted Living Services                   |   |
| Chore Services                             |   |
| Environmental Accessibility Adaptations    |   |
| Home Delivered Meals                       |   |
| Personal Emergency Response Systems (PERS) |   |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (5 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 1**

| Waiver Service/<br>Component                             | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost        |
|--|------|---------|---------------------|-----------------|----------------|-------------------|
| <b>Case Management Total:</b>                            |      |         |                     |                 |                | <b>1586130.00</b> |
| Case Management Public                                   |      |         |                     |                 | 1487526.00     |                   |
| Case Management Private                                  |      |         |                     |                 | 98604.00       |                   |
| <b>Homemaker Total:</b>                                  |      |         |                     |                 |                | <b>240669.00</b>  |
| Homemaker  |      |         |                     |                 | 240669.00      |                   |
| <b>Respite Total:</b>                                    |      |         |                     |                 |                | <b>92390.76</b>   |
| Respite  |      |         |                     |                 | 92390.76       |                   |
| <b>Attendant Care Services Total:</b>                    |      |         |                     |                 |                | <b>3824528.00</b> |
| Agency   |      |         |                     |                 | 3355824.00     |                   |
| Non-Agency   |      |         |                     |                 | 468704.00      |                   |
| <b>Specialized Medical Equipment and Supplies Total:</b> |      |         |                     |                 |                | <b>33900.00</b>   |
| Specialized Medical Equipment and Supplies               |      |         |                     |                 | 33900.00       |                   |
| <b>Assisted Living Services Total:</b>                   |      |         |                     |                 |                | <b>1279278.00</b> |
| Assisted Living Services                                 |      |         |                     |                 | 1279278.00     |                   |
| <b>Chore Services Total:</b>                             |      |         |                     |                 |                | <b>7861.07</b>    |
| Chore Services   |      |         |                     |                 | 7861.08        |                   |
| <b>Environmental Accessibility Adaptations Total:</b>    |      |         |                     |                 |                | <b>145350.00</b>  |
| Environmental Accessibility Adaptations                  |      |         |                     |                 | 145350.00      |                   |
| <b>Home Delivered Meals Total:</b>                       |      |         |                     |                 |                | <b>654925.00</b>  |
| Home Delivered Meals                                     |      |         |                     |                 | 654925.00      |                   |
| <b>Personal Emergency Response Systems (PERS) Total:</b> |      |         |                     |                 |                | <b>143430.00</b>  |
| PERS Monthly Fee   |      |         |                     |                 | 141180.00      |                   |
| PERS Installation  |      |         |                     |                 | 2250.00        |                   |
| <b>GRAND TOTAL:</b>                                      |      |         |                     |                 |                | <b>8008461.83</b> |
| Total Estimated Unduplicated Participants:               |      |         |                     |                 |                | <b>771</b>        |
| Factor D (Divide total by number of participants):       |      |         |                     |                 |                | <b>10387.11</b>   |
| Average Length of Stay on the Waiver:                    |      |         |                     |                 |                |                   |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 2

| Waiver Service/<br>Component                             | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|------|---------|---------------------|-----------------|----------------|------------|
| <b>Case Management Total:</b>                            |      |         |                     |                 |                | 1794872.51 |
| Case Management Public                                   |      |         |                     |                 | 1682030.69     |            |
| Case Management Private                                  |      |         |                     |                 | 112841.82      |            |
| <b>Homemaker Total:</b>                                  |      |         |                     |                 |                | 270562.50  |
| Homemaker  |      |         |                     |                 | 270562.50      |            |
| <b>Respite Total:</b>                                    |      |         |                     |                 |                | 103398.75  |
| Respite  |      |         |                     |                 | 103398.75      |            |
| <b>Attendant Care Services Total:</b>                    |      |         |                     |                 |                | 4322755.52 |
| Agency   |      |         |                     |                 | 3818971.20     |            |
| Non-Agency   |      |         |                     |                 | 503784.32      |            |
| <b>Specialized Medical Equipment and Supplies Total:</b> |      |         |                     |                 |                | 38544.00   |
| Specialized Medical Equipment and Supplies               |      |         |                     |                 | 38544.00       |            |
| <b>Assisted Living Services Total:</b>                   |      |         |                     |                 |                | 1390607.99 |
| Assisted Living Services                                 |      |         |                     |                 | 1390607.99     |            |
| <b>Chore Services Total:</b>                             |      |         |                     |                 |                | 8928.38    |
| Chore Services   |      |         |                     |                 | 8928.38        |            |
| <b>Environmental Accessibility Adaptations Total:</b>    |      |         |                     |                 |                | 163651.18  |
| Environmental Accessibility Adaptations                  |      |         |                     |                 | 163651.18      |            |
| <b>Home Delivered Meals Total:</b>                       |      |         |                     |                 |                | 748895.18  |
| Home Delivered Meals                                     |      |         |                     |                 | 748895.18      |            |
| <b>Personal Emergency Response Systems (PERS) Total:</b> |      |         |                     |                 |                | 162902.56  |
| PERS Monthly Fee   |      |         |                     |                 | 160203.82      |            |

|  |  |  |  |  |         |            |
|--|--|--|--|--|---------|------------|
| PERS Installation                                  |  |  |  |  | 2698.74 |            |
| <b>GRAND TOTAL:</b>                                |  |  |  |  |         | 9005118.57 |
| Total Estimated Unduplicated Participants:         |  |  |  |  |         | 844        |
| Factor D (Divide total by number of participants): |  |  |  |  |         | 10669.57   |
| Average Length of Stay on the Waiver:              |  |  |  |  |         |            |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (7 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 3

| Waiver Service/<br>Component                             | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|------|---------|---------------------|-----------------|----------------|------------|
| <b>Case Management Total:</b>                            |      |         |                     |                 |                | 2026864.15 |
| Case Management Public                                   |      |         |                     |                 | 1901802.24     |            |
| Case Management Private                                  |      |         |                     |                 | 125061.91      |            |
| <b>Homemaker Total:</b>                                  |      |         |                     |                 |                | 304153.20  |
| Homemaker  |      |         |                     |                 | 304153.20      |            |
| <b>Respite Total:</b>                                    |      |         |                     |                 |                | 117564.00  |
| Respite  |      |         |                     |                 | 117564.00      |            |
| <b>Attendant Care Services Total:</b>                    |      |         |                     |                 |                | 4869351.36 |
| Agency   |      |         |                     |                 | 4329230.40     |            |
| Non-Agency   |      |         |                     |                 | 540120.96      |            |
| <b>Specialized Medical Equipment and Supplies Total:</b> |      |         |                     |                 |                | 43477.20   |
| Specialized Medical Equipment and Supplies               |      |         |                     |                 | 43477.20       |            |
| <b>Assisted Living Services Total:</b>                   |      |         |                     |                 |                | 1578151.08 |
| Assisted Living Services                                 |      |         |                     |                 | 1578151.08     |            |
| <b>Chore Services Total:</b>                             |      |         |                     |                 |                | 10034.26   |
| Chore Services   |      |         |                     |                 | 10034.26       |            |
| <b>Environmental Accessibility Adaptations Total:</b>    |      |         |                     |                 |                | 186481.98  |
| Environmental Accessibility Adaptations                  |      |         |                     |                 | 186481.98      |            |
| <b>Home Delivered Meals Total:</b>                       |      |         |                     |                 |                | 850816.92  |
| Home Delivered Meals                                     |      |         |                     |                 | 850816.92      |            |

|  |  |  |  |  |                  |                    |
|--|--|--|--|--|------------------|--------------------|
| <b>Personal Emergency Response Systems (PERS) Total:</b> |  |  |  |  |                  | <b>185297.57</b>   |
| PERS Monthly Fee   |  |  |  |  | <b>182266.64</b> |                    |
| PERS Installation  |  |  |  |  | <b>3030.93</b>   |                    |
| <b>GRAND TOTAL:</b>                                      |  |  |  |  |                  | <b>10172191.72</b> |
| Total Estimated Unduplicated Participants:               |  |  |  |  |                  | <b>921</b>         |
| Factor D (Divide total by number of participants):       |  |  |  |  |                  | <b>11044.72</b>    |
| Average Length of Stay on the Waiver:                    |  |  |  |  |                  |                    |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 4

| Waiver Service/Component                                 | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost    | Total Cost        |
|--|------|---------|---------------------|-----------------|-------------------|-------------------|
| <b>Case Management Total:</b>                            |      |         |                     |                 |                   | <b>2366819.70</b> |
| Case Management Public                                   |      |         |                     |                 | <b>2223022.20</b> |                   |
| Case Management Private                                  |      |         |                     |                 | <b>143797.50</b>  |                   |
| <b>Homemaker Total:</b>                                  |      |         |                     |                 |                   | <b>344058.00</b>  |
| Homemaker  |      |         |                     |                 | <b>344058.00</b>  |                   |
| <b>Respite Total:</b>                                    |      |         |                     |                 |                   | <b>132438.27</b>  |
| Respite  |      |         |                     |                 | <b>132438.27</b>  |                   |
| <b>Attendant Care Services Total:</b>                    |      |         |                     |                 |                   | <b>5543656.96</b> |
| Agency   |      |         |                     |                 | <b>4923228.16</b> |                   |
| Non-Agency   |      |         |                     |                 | <b>620428.80</b>  |                   |
| <b>Specialized Medical Equipment and Supplies Total:</b> |      |         |                     |                 |                   | <b>49950.40</b>   |
| Specialized Medical Equipment and Supplies               |      |         |                     |                 | <b>49950.40</b>   |                   |
| <b>Assisted Living Services Total:</b>                   |      |         |                     |                 |                   | <b>1813169.60</b> |
| Assisted Living Services                                 |      |         |                     |                 | <b>1813169.60</b> |                   |
| <b>Chore Services Total:</b>                             |      |         |                     |                 |                   | <b>11522.74</b>   |
| Chore Services   |      |         |                     |                 | <b>11522.74</b>   |                   |
| <b>Environmental Accessibility Adaptations Total:</b>    |      |         |                     |                 |                   | <b>214246.80</b>  |
| Environmental  |      |         |                     |                 | <b>214246.80</b>  |                   |

|  |  |  |  |  |                  |                    |
|--|--|--|--|--|------------------|--------------------|
| Accessibility Adaptations                                |  |  |  |  |                  |                    |
| <b>Home Delivered Meals Total:</b>                       |  |  |  |  |                  | <b>966364.18</b>   |
| Home Delivered Meals                                     |  |  |  |  | <b>966364.18</b> |                    |
| <b>Personal Emergency Response Systems (PERS) Total:</b> |  |  |  |  |                  | <b>210333.76</b>   |
| PERS Monthly Fee   |  |  |  |  | <b>206851.96</b> |                    |
| PERS Installation  |  |  |  |  | <b>3481.80</b>   |                    |
| <b>GRAND TOTAL:</b>                                      |  |  |  |  |                  | <b>11652560.41</b> |
| Total Estimated Unduplicated Participants:               |  |  |  |  |                  | <b>1010</b>        |
| Factor D (Divide total by number of participants):       |  |  |  |  |                  | <b>11537.19</b>    |
| Average Length of Stay on the Waiver:                    |  |  |  |  |                  |                    |

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 5

| Waiver Service/Component                                 | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost    | Total Cost        |
|--|------|---------|---------------------|-----------------|-------------------|-------------------|
| <b>Case Management Total:</b>                            |      |         |                     |                 |                   | <b>2684543.70</b> |
| Case Management Public                                   |      |         |                     |                 | <b>2535816.00</b> |                   |
| Case Management Private                                  |      |         |                     |                 | <b>148727.70</b>  |                   |
| <b>Homemaker Total:</b>                                  |      |         |                     |                 |                   | <b>485550.00</b>  |
| Homemaker  |      |         |                     |                 | <b>485550.00</b>  |                   |
| <b>Respite Total:</b>                                    |      |         |                     |                 |                   | <b>169755.75</b>  |
| Respite  |      |         |                     |                 | <b>169755.75</b>  |                   |
| <b>Attendant Care Services Total:</b>                    |      |         |                     |                 |                   | <b>7351404.80</b> |
| Agency   |      |         |                     |                 | <b>6390320.00</b> |                   |
| Non-Agency   |      |         |                     |                 | <b>961084.80</b>  |                   |
| <b>Specialized Medical Equipment and Supplies Total:</b> |      |         |                     |                 |                   | <b>58194.90</b>   |
| Specialized Medical Equipment and Supplies               |      |         |                     |                 | <b>58194.90</b>   |                   |
| <b>Assisted Living Services Total:</b>                   |      |         |                     |                 |                   | <b>2812302.90</b> |
| Assisted Living Services                                 |      |         |                     |                 | <b>2812302.90</b> |                   |
| <b>Chore Services Total:</b>                             |      |         |                     |                 |                   | <b>21294.69</b>   |

|  |  |  |  |  |            |             |
|--|--|--|--|--|------------|-------------|
| Chore Services   |  |  |  |  | 21294.69   |             |
| <b>Environmental Accessibility Adaptations Total:</b>    |  |  |  |  |            | 443062.80   |
| Environmental Accessibility Adaptations                  |  |  |  |  | 443062.80  |             |
| <b>Home Delivered Meals Total:</b>                       |  |  |  |  |            | 1172331.16  |
| Home Delivered Meals                                     |  |  |  |  | 1172331.16 |             |
| <b>Personal Emergency Response Systems (PERS) Total:</b> |  |  |  |  |            | 248954.40   |
| PERS Monthly Fee   |  |  |  |  | 244068.54  |             |
| PERS Installation  |  |  |  |  | 4885.85    |             |
| <b>GRAND TOTAL:</b>                                      |  |  |  |  |            | 15447395.09 |
| Total Estimated Unduplicated Participants:               |  |  |  |  |            | 1105        |
| Factor D (Divide total by number of participants):       |  |  |  |  |            | 13979.54    |
| Average Length of Stay on the Waiver:                    |  |  |  |  |            |             |