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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Commonwealth Coordinated Care Plus

C. Waiver Number:VA.0321
Original Base Waiver Number: VA.0321.9

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
01/01/25
Approved Effective Date of Waiver being Amended: 10/01/23

2. Purpose(s) of Amendment

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

The purpose of this amendment is to make changes as a result of actions passed and funded by the Virginia General Assembly. The following changes are being made to this waiver:

1. HB909/SB488 (2024): Finalizing rules regarding when a Legally Responsible Individual (LRI) is the paid aide/attendant for the personal care service;
2. HB291/SB24 (2024): Adding Nursing Facilities as an allowable entity to screen individuals for entry into the waiver;
3. HB729/SB620 (2024): Adding Program of All-Inclusive Care for the Elderly (PACE) sites as an allowable entity to screen individuals for entry into the waiver;
4. Item 288.CCCCC (2024): Removing educational requirements for providers of Consumer-Directed Services Facilitation; and
5. Updating language as to who is responsible for conducting the annual level of care review for waiver individuals who are fee-for-service.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A Waiver Administration and Operation	
☒ Appendix B Participant Access and Eligibility	B6
☒ Appendix C Participant Services	C1/C3, C2
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☐ Appendix I Financial Accountability	
☐ Appendix J Cost-Neutrality Demonstration	

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

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☒ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☒ **Other**

Specify:

Updating the allowable entities that can conduct initial LTSS screenings for entry into the waiver.

Updating that a DMAS-contracted entity conducts the annual level of care review for individuals who are fee-for-service instead of the provider.

Updating rules pertaining to services provided by a legally responsible individual.

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

1. Request Information (1 of 3)

A. The **State** of **Virginia** 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*):

Commonwealth Coordinated Care Plus

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: VA.0321
Draft ID: VA.004.05.03

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/23
Approved Effective Date of Waiver being Amended: 10/01/23

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

☒ **Hospital**

Select applicable level of care

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

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

An individual must be chronically ill or severely impaired and require both a medical device to compensate for the loss of a vital body function and substantial ongoing nursing care to avert death or further disability. The requirement for a medical device to compensate for the loss of a vital body function may include one or more of the following categories.

* Individuals dependent at least part of each day on mechanical ventilators, and
* Individuals meeting specialized tracheotomy criteria.

The need for substantial and ongoing nursing is determined by the score an individual receives on the Objective Scoring Tool. Individuals must score a minimum 50 in the Technology section of the tool to receive services.

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

☒ **Nursing Facility**

Select applicable level of care

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

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

1) Nursing facility level of care; and
2) Specialized nursing facility level of care

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

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

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

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

A 1915(b) waiver has been submitted concurrently with this waiver renewal. The 1915 (b) waiver is referred to as, "Cardinal Care."

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

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

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

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

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

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

2. Brief Waiver Description

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

The Commonwealth Coordinated Plus (CCC+) waiver provides home and community-based services to individuals who meet the nursing facility, specialized care facility, or hospital level of care. The individuals receiving services through the waiver have been determined to be at risk for institutional placement in the absence of waiver services.

The goal of the CCC+ Waiver is to incorporate the principles of self-determination and supplement community supports while fostering dignity, quality of life, and security in the everyday lives of individuals who are medically fragile, older adults or have disabilities while maintaining the individual in the community. The CCC+ Waiver offers an array of services to support community living and includes self-directed options to allow for greater individual autonomy. All services are offered statewide and include Adult Day Health Care, Assistive Technology, Environmental Modifications, Personal Assistance services, Personal Emergency Response Systems, Respite services, Services Facilitation, Skilled Private Duty Nursing, and Transition Services. The individual may elect to self-direct Personal Assistance Services and Respite Services.

The objectives of the CCC+ Waiver are to:
1) Promote independence for participants through high quality services and the assurance of health, safety, and welfare through a comprehensive quality management strategy;
2) Offer an alternative to institutionalization and costly comprehensive services through an array of community supports that promote inclusion and independence by enhancing rather than replacing existing informal supports;
3) Support participants and their families to share responsibility for their supports and services.

The Virginia Department of Medical Assistance Services (DMAS) is the Single State agency which maintains administrative and quality oversight of the CCC+ waiver. Beginning July 1, 2017, Virginia will begin phasing in the delivery of long-term services and supports through an integrated model of care that includes both HCBS and institutional based services, behavioral health, primary, and acute services through capitated Medicaid managed care plans. This will be accomplished by using combined 1915(b) and 1915(c) waiver authority. This provides an opportunity to create a seamless, integrated health services delivery system with goals that include:

- Improved quality of life, satisfaction, and health outcomes for individuals who are enrolled;
- A seamless, one-stop system of services and supports;
- Service coordination that provides assistance in navigating the service environment, timely and effective transfer of information, and tracking of referrals and transitions to identify and overcome barriers;
- Care coordination for individuals with complex needs that integrates the medical and social models of care, ensures individual choice and rights, and includes individuals and family members in decision making using a person-centered model;
- Support for transitions between service/treatment settings;
- Facilitation of communication among providers to improve the quality and cost effectiveness of care;
- Arrangement of services and supports to maximize opportunities for community living; and,
- System-wide quality improvement and monitoring.

DMAS contracts with the Virginia Departments of Health and Social Services and acute care hospitals to conduct initial level of care screenings for individuals. Services are accessed via these community-based or hospital screeners. Individuals opting to receive services in the community through the CCC+ Waiver choose the types of services needed, the method of service delivery (agency-directed, consumer-directed, or both) and the providers of those services. All services must be authorized and delivered in accordance with the individual plan of care. The average participant's expenditures for all waiver services shall not exceed the average Medicaid expenditures for nursing facility or acute care hospital placement. DMAS utilizes contractual services of fiscal agent entities. In addition, DMAS contracts with a service authorization contractor for services provided through fee for service (FFS).

While the majority of individuals will receive these services through a managed care organization, there will be some that will continue in the fee for service model for a finite period of time. Individuals may receive services through the FFS model until MCO enrollment occurs which is the 1st of the month.

3. Components of the Waiver Request

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

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

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid

eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- (●) **No**
- ( ) **Yes**

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

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

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect

to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery

processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

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

The Department of Medical Assistance Services requested tribal and public feedback prior to submission of this renewal application.

A written notice was sent to Native American tribes in Virginia on January 19, 2022 providing an opportunity of 60 days to provide feedback. The following tribes were notified: Pamunkey Indian Tribe, Chickahominy Indian Tribe, Monacan Indian Nation Inc., Nansemond Indian Tribe, Rappahannock Tribe, Eastern Chickahominy Indian Tribe, and Upper Mattaponi Tribe. No comments were received.

On February 14, 2022, DMAS opened this renewal application for public comment. Notice was published in the Sunday, February 13, 2022 newspapers and in online editions for ten days (February 13 to February 22). Further, provider associations were emailed on Friday, February 11, 2022 of the public comment period, and the managed care organizations with which DMAS contracts were notified as well. DMAS received no comments during the public comment period.

Waiver Amendment Effective November 11, 2023

A public comment period for the proposed amendment was made available from June 27, 2023 to July 27, 2023. Tribes in Virginia were also notified of these renewals on June 1, 2023 with a request for any comments. The following tribes were notified: Pamunkey Indian Tribe, Chickahominy Indian Tribe, Monacan Indian Nation Inc., Nansemond Indian Tribe, Rappahannock Tribe, and Upper Mattaponi Tribe. No comments were received.

DMAS provided notice of public comment through an online notification posted to the agency's website for the duration of the thirty day period. The waiver application with amendments were available for public viewing on the DMAS agency website along with how to submit questions and/or comments via the Virginia Town Hall website, email, fax, and mail.

DMAS also solicited public comment in the Richmond Times-Dispatch, both the print edition and online through the newspaper's website. The print solicitation was published in the newspaper on Sunday, July 2, 2023. The online solicitation ran on the Richmond Times-Dispatch website from Sunday July 2, 2023 through Tuesday, July 11, 2023. Instructions were provided both print and online on the methods to submit questions and comments as well as direct link to the waiver applications available on the DMAS website.

DMAS received a total of 293 comments during the public comment period. The comments were able to be broken down into the following categories:

1. The overwhelming majority of the comments pertained to the state's proposed action to allow legally responsible individuals to provide paid personal attendant care in the Family and Individual Supports Waiver. Commonly cited concerns were raised regarding the 40-hour limitation and rules regarding the Employer of Record (EOR) in the Consumer-Directed model, with early comments pointing out language that would have restricted all relatives from being the EOR. Some comments indicated general opposition to the proposal as burdensome or restrictive, while others showed general support to allow legally responsible individuals to continue to be paid to provide personal care/personal assistance.

DMAS Response: DMAS developed a factsheet to address these concerns and has posted the factsheet on the Waivers page at the start of the public comment period (https://dmas.virginia.gov/for-providers/long-term-care/waivers/). In developing the rules to allow legally responsible individuals to be the paid personal assistant, DMAS considered the CMS requirements of defining extraordinary care, responding to possible conflict of interest, ensuring that services are adequately provided and billed, and establishing that such a provision of services is in the waiver individual's best interests. During the comment period, when it was realized of the language that the EOR would not be permitted to be any relative, DMAS updated the application and fact sheet to revise that error.

2. A handful of comments were focused on items not being affected by the waiver amendment, such as other services, asking for coverage or increased rates. One comment requested changes to technical language throughout the applications.

DMAS Response: DMAS started these amendments with the intent of a narrow scope to ensure a continuity of the provision to compensate legally responsible individuals to provide the personal care/personal assistance service with the

approaching end of the state's Appendix K flexibilities. Technical changes to language throughout the application will be added in a future amendment. DMAS is also unable to add new services or increase rates to services without state legislative authority.

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

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

7. Contact Person(s)

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

Last Name: Martin

First Name: Nichole

Title: Director, Office of Community Living

Agency: Virginia Department of Medical Assistance Services

Address: 600 East Broad Street

Address 2:

City: Richmond

State: **Virginia**

Zip: 23219

Phone: (804) 371-5016 **Ext:** ☐ **TTY**

Fax: (804) 612-0040

E-mail: nichole.martin@dmas.virginia.gov

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: **Virginia**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Virginia**

Zip:

Phone:

Ext: **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

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

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

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver

complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

◉ **The Medical Assistance Unit.**

Specify the unit name:

Office of Community Living

(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

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

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.:*

Virginia DMAS contracts with the following entities related to the respective roles:

1)Virginia Department of Health (VDH) and Virginia Department of Aging and Rehabilitative Services (DARS) are contracted through Inter-Agency Agreements to serve as the community level point of entry into the waiver. Screening teams made up of family services specialists from VDSS and a RN from VDH conduct initial level of care screenings. A physician from VDH reviews and provides final signature for the screening determination decision.
The screenings are conducted on-site at the individual's home. The screeners provide information about the waiver and offer choice between institutional and community-based services. Appropriate referrals are made based on the individual's choices.

Individuals are also screened in acute care and rehabilitation hospitals as well as skilled nursing facilities.

32.1-330 of the Code of Virginia requires screening to be conducted by teams that are either community-based, in acute care hospitals, or in skilled nursing facilities. For children under the age of 21, the Virginia Department of Health serves as the single point of entry for screening conducted in the community.

Those who qualify for services may choose the types of services they need, the method of service delivery (agency-directed, consumer-directed, or both) and the provider(s) of those services.

2)A Service Authorization contractor receives and review service authorization requests for individuals receiving FFS. The contractor reviews the individual's health assessment and plan of care to ensure services meet waiver requirements including meeting LOC requirements for the waiver, and service limits are not exceeded. Service authorization is required initially, annually, and as needs change. Individual's enrolled in managed care will have services authorized by the MCO.

3)A Fiscal Management Agent contractor performs provider enrollment, provides management of the Virginia MMIS and performs fiscal intermediary services. MCOs perform provider enrollment and claims payment functions for providers within their networks.

4)A Fiscal/Employer Agent(FEA) is contracted to perform the functions of the fiscal management services for consumer-direction. The FEA conducts payment activities on behalf of the individual receiving consumer-directed services. The FEA is responsible for calculating and filing all employer related taxes and makes payment to attendants on a bi-weekly basis. MCOs are required to contract with the DMAS FEA for fiscal management services for consumer-direction.

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

The Virginia Department of Medical Assistance Services maintains responsibility for assessing the performance of contracted entities. DMAS employees provide daily oversight of administrative operations and periodically evaluate outcomes and deliverables from each contractor.

Appendix A: Waiver Administration and Operation

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

Virginia DMAS is responsible for the assessment of performance of all contracted entities that take part in waiver operational and/or administrative functions. Medicaid agency employees are assigned the duties of contract monitor to oversee and ensure the performance of the contracted entities and complete an evaluation every six months. Contract monitors are responsible for:

1) Coordinating and overseeing the day-to-day delivery of services under the contract, including assurance that information about the waiver is given to potential enrollees; that individuals are assisted with waiver enrollment; that level of care evaluations are completed; that waiver requirements are met; that service authorization is conducted in accordance with review criteria and approved procedures; that the terms and conditions of the contract/agreement are met; and that claims for services are paid appropriately;
2) Ensuring that services are delivered in accordance with the contract and that deliverables are in fact delivered;
3) Approving invoices for payment in accordance with the terms of the contract;
4) Completing and submitting a semi-annual report to the DMAS Contract Officer;
5) Reporting any delivery failures or performance problems to the DMAS Contract Officer; and
6) Ensuring that the contract terms and conditions are not extended, increased, or modified without proper authorization.

The Department's evaluation measures include:
1) Has the contractor/agency complied with all terms and conditions of the contract/agreement during the period of this evaluation?
2) Have deliverables required by the contract/interagency agreement been delivered timely?
3) Has the quality of services required by the contract/interagency agreement been satisfactory during the evaluation period?
4) Are there any issues or problems you wish to bring to management's attention at this time?
5) Do you need assistance in handling any issues or problems associated with the contract/interagency agreement?
6) From an overall standpoint, are you satisfied with the contractor's/agency's performance?

DMAS staff will provide oversight and on-going monitoring of the MCOs providing waiver services. Staff will conduct monitoring of systems, data, and reporting to ensure service quality and adequacy. DMAS will track and analyze data from each health plan that support program operations including authorization and provider network data.

Additionally, as part of NCQA requirements, the health plans are required to perform all HEDIS measures that meet the minimum criteria for calculation. Measure selection will be driven by the goals and objectives of the Cardinal Care managed care Program and align with Federal and State health care priorities. Ongoing performance measure trending will be conducted for Cardinal Care managed care. The Department will require corrective action plans for those measures falling below Department established benchmarks.

The Department, in collaboration with the health plans, the External Quality Review Organization (EQR0), other state agencies, and stakeholders will conduct on-going monitoring activities to ensure compliance to managed care program requirements and the provision of quality of care for all CCC+ waiver participants. Monitoring mechanisms will include but not be limited to: frequent meetings or conference calls; evaluation of complaint and other required reports; Good Cause requests; Program Integrity audits; EQRO reviews; information provided to participants through mailings or that is available on the DMAS/Managed Care websites; and information provided by the enrollment broker and DMAS helplines. This continual monitoring will be done to meet federal and state regulatory compliance, and to fulfill the DMAS managed care goal which is, "to provide a cost-effective managed care delivery system for eligible Medicaid participants that exceeds the industry standards for timeliness, access and quality of care."

The close, continuous, and on-going monitoring efforts and hands-on attention to participant complaints allows the Department to identify potential problem areas, to identify patterns or trends in the type of problems, to identify whether the problems stem from programmatic issues, and to correct or address any problems through clarification memos or contract amendments. For additional details of the MCO monitoring plan, please refer to the 1915 (b) application.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the

performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
AA1. Number and percent of records reviewed during the Quality Management Review process according to the sampling methodology specified in the waiver. N: Number of records reviewed during the QMR process D: Number required based on sampling methodology

Data Source (Select one):
Other
If 'Other' is selected, specify:
QMR reports

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

Data Aggregation and Analysis:

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

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

Performance Measure:
AA2. Number and percent of satisfactory Interagency Agreement/Contract evaluations. N: # of satisfactory Interagency Agreements/Contract evaluations; D: Total # of Interagency Agreements/ contracts with entities performing functions related to the waiver.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
AA3. Number and percent of MCO QMR reports submitted according to the CCC Plus Waiver Technical Guide. N: # of reports submitted D: Total # of required reports

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

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

		Review
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

If a problem is discovered, the assigned DMAS Long-Term Care Quality Improvement Team (QIT) staff will work with the specific DMAS contract monitor and the DMAS Budget and Contract Unit to implement corrective action.

ii. Remediation Data Aggregation

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

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

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 ï¿½441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☒	**Aged**	65		☒
	☒	**Disabled (Physical)**	0	64	
	☒	**Disabled (Other)**	0	64	
☒ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☒	**Technology Dependent**	0		☒
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

To meet the subgroup criteria for technology dependent, an individual must be chronically ill or severely impaired and require both a medical device to compensate for the loss of a vital body function and substantial ongoing nursing care to avert death or further disability. The requirement for a medical device to compensate for the loss of a vital body function may include one or more of the following categories.

* Individuals dependent at least part of each day on mechanical ventilators, and
* Individuals meeting specialized tracheotomy criteria.

The need for substantial and ongoing skilled nursing is determined by the score an individual receives on the Objective Scoring Tool. Individuals must score a minimum 50 in the technology section of the tool to receive services.

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:

Not applicable. No maximum age limits apply.

Appendix B: Participant Access and Eligibility

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

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

- (●) **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

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

    Specify the percentage:

  - ( ) **Other**

    Specify:

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

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

  - ( ) **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

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

      Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the

number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	50040
Year 2	50645
Year 3	51998
Year 4	53351
Year 5	54704

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:

Virginia provides home and community-based services to individuals who are elderly and/or have disabilities and who meet the nursing facility or hospital level of care criteria. Individuals who meet the functional, medical/nursing need and financial eligibility criteria receive a waiver slot and choose the services needed, select the providers of those services, and may opt to self-direct care for certain services. DMAS does not maintain a waiting list for the CCC Plus Waiver; participants are served on a first come, first served basis.

Participants who have their acute care services covered by a managed care organization will request and enroll in the CCC Plus Waiver by the same process.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

2. Miller Trust State.

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

- (●) **No**
- ( ) **Yes**

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

limits under the plan. *Check all that apply*:

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

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

  Select one:

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

    Specify percentage: 80

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

  Specify:

  Caretaker relatives specified at 435.110, pregnant women specified at 435.116, and children specified at 435.118.

  Coverage for individuals age 19 or older and under age 65 in accordance with 435.119

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

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

  Select one and complete Appendix B-5.

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

    Check each that applies:

    - ☐ **A special income level equal to:**

Select one:

- ○ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

  Specify percentage: [ ]
- ○ **A dollar amount which is lower than 300%.**

  Specify dollar amount: [ ]

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

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

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

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

Select one:

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

  Specify percentage amount: [ ]

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

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

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

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

- (●) **Use spousal post-eligibility rules under §1924 of the Act.**
  (Complete Item B-5-c (209b 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-c (209b 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-c (209b 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.

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (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.

The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR 435.735 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 amounts 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*):

( ) **The following standard under 42 CFR §435.121**

Specify:

( ) **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 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:

The basic maintenance needs for an individual is equal to 165% of the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% of SSI; for an individual employed at least 4 hours but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

○ **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*):

○ **The following standard under 42 CFR §435.121**

Specify:

○ **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 (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:

  The basic maintenance needs for an individual is equal to 165% of the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% of SSI; for an individual employed at least 4 hours but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.
- ○ **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 or §1634 State - 2014 through 2018.

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (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 the selections in B-5-c also apply to B-5-f.

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 the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

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

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

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

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

Specify the entity:

- (●) **Other**

Specify:

The State Code of Virginia, § 32.1-330 states that all individuals who are requesting community based or nursing facility (NF) long-term care services and supports (LTSS), require a screening to determine if they meet the level of care needed for NF services. DMAS contracts with the Virginia Department of Health (VDH), Department of Aging and Rehabilitation Services (DARS), and hospitals to conduct level of care screenings. In the community, screeners are locality staff including nurses and physicians from the Virginia Department of Health and family services specialists from the local departments of social services (LDSS). Acute care hospitals utilize discharge planners to complete the screening that is reviewed and signed by a physician.

In the case an individual in the community expresses an interest for nursing facility care and has an immediate need for LTSS services where the community-based screening team cannot conduct the LTSS screening timely, an individual may be screened by a nursing facility prior to admission to the nursing facility. Should the individual meet the level of care, the qualified screener at the nursing facility must offer choice of LTSS model, including CCC Plus waiver.

In the case an individual in the community expresses an interest for PACE enrollment and has an immediate need for LTSS services where the community-based screening team cannot conduct the LTSS screening timely, an individual may be screened by a PACE site prior to enrollment in the program. Should the individual meet the level of care, the qualified screener at the PACE site must offer choice of LTSS model, including CCC Plus waiver.

All screenings include a face-to-face assessment with the individual and family or caregivers, as appropriate, to determine the individuals' needs based on functional criteria, medical and nursing needs, and the risk for placement into an institution in the absence of waiver services. This standardized assessment is documented on the Virginia Uniform Assessment Instrument (UAI), which guides the team in identifying the individual's appropriate LOC requirements based on medical needs and circumstances. The documentation of the face-to-face screening is reviewed by the physician. If services are needed, each member of the screening team must sign the Medicaid Funded Long-Term Care Service Authorization form that identifies the LOC of the individual and deems the information valid for enrollment into the CCC+ Waiver. This process is the same for all populations including those enrolled in FFS and Cardinal Care.

DMAS conducts annual level of care re-evaluations to ensure all individuals enrolled in the waiver continue to meet the eligibility criteria to receive waiver services. The MCO or the fee for service provider completes the Level of Care Eligibility Re-determination Instrument(LOCERI) that documents the functional status, medical and nursing needs and physical health of the participant. The MCO or provider submits the information to DMAS through a secure web-portal that is programmed to validate the participant's level of care. In the event that the electronic validation check determines the individual no longer meets the criteria for services, a referral is generated and sent to a DMAS RN and a higher level review and re-determination is conducted. The RN performs an independent assessment and makes a final determination.

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:

Initial level of care evaluations must be completed by a team of individuals with the minimum qualifications listed below:

1) A registered nurse licensed in the Commonwealth of Virginia;
2) A social worker or family services specialist;
3) A physician licensed to practice in the Commonwealth of Virginia

Family services specialist must possess a minimum of a baccalaureate degree in the human services field;or possess a minimum of a baccalaureate degree in any field accompanied by a minimum of two years appropriate and related experience in a human services related area

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.

Virginia uses the Virginia Uniform Assessment Instrument (UAI) to assess level of care criteria for the CCC+ Waiver. The UAI is the standardized multidimensional assessment instrument that is completed by the screening entity that assesses an individual's functional abilities, physical health, orientation and mental/behavioral health, social and home environment to determine if the individual meets the nursing facility level of care. The UAI fosters the sharing of information between providers, and assessors are encouraged to share information about the individual to avoid duplicative paperwork. The UAI ensures easy and equitable access to appropriate services for individuals at all levels of the long-term care spectrum. For providers, it provides a comprehensive picture of the individual and the individual's needs and is intended to facilitate the appropriate placement transfer and exchange of information among providers.

Those identified as meeting nursing facility level of care are afforded the opportunity to choose between services in an institution or home and community based supports (HCBS) including CCC+ waiver and Virginia's Program of All-Inclusive Care for the Elderly (PACE) program.

The screening criteria for assessing an individual's level of care consists of functional capacity (i.e.: ADL's and mobility) and medical or nursing needs. In order to qualify for the CCC+ waiver an individual must meet both of the components and the screening team must also document that the individual is at risk for institutional placement within 30 days in the absence of HCBS.

Functional capacity is the degree of independence that an individual can perform their activities of daily living (ADLs), including ambulation and instrumental ADLs. The functional capacity areas assessed include: bathing, dressing, toileting, transferring, bowel and bladder function, eating/feeding, joint function, ambulation/mobility, medication administration, orientation, cognition and behavior. In order to meet functional capacity eligibility criteria, an individual must meet one of the following categories:

1. Dependent in two to four of the ADLs, and also rated semi-dependent or dependent in Behavior Pattern and Orientation, and also semi-dependent in Joint Motion or dependent in Medication Administration; or
2. Rated dependent in five to seven of the ADLs and also rated dependent in Mobility; or
3. Rated semi-dependent in two to seven of the ADLs and also rated dependent in Mobility and Behavior Pattern and Orientation.

Medical or nursing needs are health needs requiring medical or nursing supervision or care above the level which could be provided through assistance with ADLs, medication administration, and general supervision and is not primarily for the care and treatment of mental diseases.

Medical or nursing supervision or care beyond this level is required when any one of the following describes the individual's need for medical or nursing supervision:

1. Medical or nursing supervision or care beyond this level is required when the individual's medical condition requires observation and assessment to assure evaluation of the individual's need for modification of treatment or additional medical procedures to prevent destabilization, and the individual has demonstrated an inability to self-observe or evaluate the need to contact skilled medical professionals; or
2. due to the complexity created by the individual's multiple, inter-related medical conditions, the potential for the individual's medical instability is high or medical instability exists; or
3. The individual requires at least one ongoing medical or nursing service. Ongoing means that the medical/nursing needs are continuing, not temporary, or where the individual is expected to undergo or develop changes with increasing severity in status.

To meet the hospital level of care, an individual must be chronically ill or severely impaired and require both a medical device to compensate for the loss of a vital body function and substantial ongoing nursing care to avert death or further disability. The requirement for a medical device to compensate for the loss of a vital body function may include one or more of the following categories.

* Individuals dependent at least part of each day on mechanical ventilators, and
* Individuals meeting specialized tracheotomy criteria.

The need for substantial and ongoing nursing is determined by the score an individual receives on the Objective Scoring Tool. Individuals must score a minimum 50 in the Technology section of the tool to receive services.

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:

The State Code of Virginia, § 32.1-330 states that all individuals who are requesting community based or nursing facility (NF) long-term care services and supports , require a screening to determine if they meet the level of care needed for NF services. DMAS contracts with the Virginia Department of Health (VDH) and has agreements with Department of Aging and Rehabilitation Services (DARS), and hospitals to conduct level of care screenings. In the community, screeners are locality staff including nurses and physicians from the Virginia Department of Health and family services specialists from DARS and the local departments of social services (ldss). Acute care hospitals utilize discharge planners to complete the screening that is reviewed and signed by a physician.

All screenings include a face-to-face assessment with the individual and family or caregivers, as appropriate, to determine the individuals' needs based on functional criteria, medical and nursing needs, and the risk for placement into an institution in the absence of waiver services. This standardized assessment is documented on the Virginia Uniform Assessment Instrument (UAI), which guides the team in identifying the individual's appropriate LOC requirements based on medical needs and circumstances. The documentation of the face-to-face screening is reviewed by the physician. If services are needed, each member of the screening team must sign the Medicaid Funded Long-Term Care Service Authorization form that identifies the LOC of the individual and deems the information valid for enrollment into the CCC+ Waiver. This process is the same for all populations including those enrolled in FFS and Cardinal Care.

DMAS conducts annual level of care re-evaluations to ensure all individuals enrolled in the waiver continue to meet the eligibility criteria to receive waiver services. The MCO or contracted entity completes the Level of Care Eligibility Re-determination Instrument(LOCERI) that documents the functional status, medical and nursing needs and physical health of the participant. The MCO or contractor submits the information to DMAS through a secure web-portal that is programmed to validate the participant's level of care. In the event that the electronic validation check determines the individual no longer meets the criteria for services, a referral is generated and sent to a DMAS RN and a higher level review and re-determination is conducted. The RN performs an independent assessment and makes a final determination.

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:

In FFS, information for annual level of care reevaluations is gathered by providers of the individual's primary service. The qualifications of the provider gathering the information is consistent with that of any of the assessors performing initial evaluations.

For individuals using consumer-directed services, the Services Facilitator gathers and reports information to DMAS. Services Facilitators possess at a minimum, either (i) an associate's degree from an accredited college in a health or human services field or be a registered nurse currently licensed to practice in the Commonwealth and possess a minimum of two years of satisfactory direct care experience supporting individuals with disabilities or older adults; or (ii) a bachelor's degree in a non-health or human services field and possess a minimum of three years of satisfactory direct care experience supporting individuals with disabilities or older adults. Services facilitators enrolled with DMAS prior to January 11, 2016 are not required to meet the education requirements specified above but must possess a combination of work experience and relevant education that indicates possession of the knowledge, skills, and abilities as required by DMAS. To demonstrate competency, all services facilitators must complete the DMAS-approved consumer-directed services facilitator training course and pass the corresponding competency assessment with a score of at least 80%.

For individuals enrolled in Cardinal Care, information is gathered and sent to DMAS by the care coordinator. The care coordinator qualifications must possess, at a minimum, either 1) a bachelor's degree in a health or human services field, 2) a Registered Nurse, or 3) a Licensed Practical Nurse.

For both FFS and managed care, DMAS conducts the reevaluation through the use of the LOCERI database. A registered nurse licensed in Virginia makes the final determination of level of care.

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):*

DMAS utilizes the LOCERI database to produce notifications when annual level of care reevaluations are due. An email is sent to the MCO or FFS service provider 45 days prior to the reevaluation due date providing notification that the level of care reevaluation is due, including the documentation that must be submitted. Lack of response from the provider or MCO prompts a second written notification at the 45 day deadline requesting the submission of reevaluation documentation within 10 business days. Upon receipt, an analyst reviews the information to assure accuracy. Missing documentation is requested from the provider by telephone or fax and MCO/providers must respond within 48 hours with the requested documentation.

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:

The initial level of care screening teams completes and submits the screening through an electronic web portal known as ePAS. The ePAS information is uploaded and maintained in Virginia's Medicaid Management Information System (VAMMIS), this information is stored permanently. Information from annual reevaluations is maintained in the DMAS LOCERI database permanently.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
LOC1. Number and percent of all new waiver enrollees who have a level of care screening that indicates a need for institutional/waiver services. N: # of new waiver enrollees who have a level of care indicating appropriate eligibility. D: # of new waiver enrollees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Enterprise System (MES)

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

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

Data Aggregation and Analysis:

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

Performance Measure:
LOC2. Number and percent of screenings conducted in a timely manner. N: # screenings conducted by the community based team within 30 days of the initial request. D: Number of screenings conducted by community based teams.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Enterprise System (MES)

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
LOC3. Number and percent of LOC reviews entered timely in the LOCERI system. N: Number of LOC reviews completed and entered in the LOCERI system within 30 days of the annual LOC due date. D: Number of LOC reviews required.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Enterprise System (MES)

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
LOC4. Number and percent of waiver individuals who did not meet LOC criteria after HLR who were terminated from the waiver after completion of appeal process (if any). N: # of waiver individuals who did not meet LOC criteria after HLR who were terminated from the waiver after completion of appeal process (if any). D: Total # of waiver individuals who did not meet LOC criteria after HLR.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Enterprise System (MES)

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
LOC5. Number and percent of higher level reviews conducted when LOCERI indicates the individual does not meet LOC eligibility. N: # of higher level review completed. D: Total # of LOC reviews that LOCERI data indicates do not meet LOC criteria.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Enterprise System (MES)

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

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

If a problem is discovered, the DMAS Quality Improvement Team (QIT) staff will work with the DMAS Level of Care Unit to implement corrective action.
Individual providers with systemic problems will be targeted for technical assistance/training from DMAS or the MCO. These events and their results will be documented in quarterly reports of technical assistance.

ii. Remediation Data Aggregation

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

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

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).

The screening teams, both community-based and those in the acute care settings notify individuals and their legal representative the choice between institutional and community-based services. This process is documented on the DMAS Recipient Choice Form (DMAS 97- rev. 8/12).

FFS
When the individual chooses community-based services, the team reviews the service options available and provides the individual with a list of providers to choose.

Cardinal Care
When the individual chooses community-based services, the team sends the information to the appropriate MCO. The MCO contacts the individual and the care coordinator conducts a face to face visit with the individual. During this visit, the individual chooses the services that best meet their needs and is provided a list of providers in the MCO's network. The care coordinator makes the initial visit within five business days of receiving the referral.

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

The Recipient Choice Form (DMAS 97)is kept in the individual's case record maintained by the provider.

Cardinal Care
The Recipient Choice Form (DMAS 97)is kept in the individual's case record maintained by the MCO.

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):

DMAS participates in a state contract for telephone-based interpretation and translation services and is available to individuals seeking information. Forms are available in alternative formats upon request. Language translation services are also available to individuals seeking assistance who contact the DMAS staff. Network Omni is the contractor the Department uses as a part of a contract secured by the State's Information Technology Agency (VITA). The department is billed on a per call basis.

Cardinal Care
Per 1915(b) waiver requirements, the managed care contractor(s) will be required to provide documents in languages other than English, when five percent of the Medicaid-eligible population is non-English speaking and speaks a common language.

MCOs must provide information to participants on how to access oral interpretation services, free of charge, for any non-English language spoken. [42CFR438.10(c)(5)(i)] MCOs must also provide a multilingual notice that describes translation services that are available and provides instructions explaining how enrollees can access those translation services. The enrollment broker also offers translations services for individuals who call with questions, who wish to change their MCO option, or who wish to enroll in an MCO.

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	**Adult Day Health Care**		
Statutory Service	**Personal Assistance Services**		
Statutory Service	**Respite Care Services**		
Supports for Participant Direction	**Services Facilitation**		
Other Service	**Assistive Technology**		
Other Service	**Environmental Modifications**		
Other Service	**Personal Emergency Response System (PERS)**		
Other Service	**Private Duty Nursing**		
Other Service	**Transition Services**		

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:

Adult Day Health

Alternate Service Title (if any):

Adult Day Health Care

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04050 adult day health

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

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

Service Definition *(Scope):*

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

Adult Day Health Care (ADHC) means long term maintenance or supportive services offered by a community-based day care program. ADHC provides a variety of health, therapeutic, and social services designed to meet the specialized needs of those waiver individuals who are elderly or who have a disability and who are at risk of placement in a nursing facility. Physical, occupational, and speech therapies indicated in the individual's plan of care may be furnished at the adult day health care center, but is not furnished as a component part of this service.

Transportation between the individual's place of residence and the adult day health care center will not be provided as a component part of the adult day health services. If the adult day health care provider wishes to and is able to provide transportation services to the recipient, DMAS may reimburse the provider for these services.

ADHC Centers must provide at least one meal per day, which supplies one-third of the daily nutritional requirements established by the U.S. Department of Agriculture. Special diets and counseling must be provided as requested or as necessary.

Adult day health care is furnished 6 or more hours per day on a regularly scheduled basis as specified in the service plan.

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	Adult Day Health Care Center

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health Care

Provider Category:

Agency

Provider Type:

Adult Day Health Care Center

Provider Qualifications

License *(specify):*

Agency providers of Adult Day Health Care must be licensed by the Virginia Department of Social Services in accordance with 22VAC40-61-60.

MCOs will be required, at minimum, to have providers in their region meet DMAS standards for FFS providers. Agencies must be credentialed through the MCO.

Certificate *(specify):*

Other Standard *(specify):*

The following DMAS special participation standards are imposed in addition to DSS standards and shall be met in order to provide Medicaid adult day health care services:

a. Provide a separate room or an area equipped with one bed, cot, or recliner for every 12 adult day health care participants;

b. Employ sufficient interdisciplinary staff to adequately meet the health, maintenance, and safety needs of each participant;

c. Maintain a minimum staff-to-participant ratio of at least one staff member to every six participants. This includes Medicaid and other participants;

d. Provide at least two staff members awake and on duty at the ADHC at all times when there are Medicaid participants in attendance;

e. In the absence of the director, designate the activities director, registered nurse, or therapist to supervise the program;

f. May include volunteers in the staff-to-participant ratio if these volunteers meet the qualifications and training requirements for compensated employees, and, for each volunteer so counted, include at least one compensated employee in the staff-to-participant ratio;

g. For any center that is co-located with another facility, count only its own separate identifiable staff in the center's staff-to-participant ratio; and

h. Employ the following:

(1) A director who shall be responsible for overall management of the center's programs. The director shall be the provider contact person for DMAS and the designated preauthorization contractor and shall be responsible for responding to communication from DMAS and the designated preauthorization contractor.

(a) The director shall be responsible for assuring the development of the plan of care for adult day health care individuals. The director has ultimate responsibility for directing the center program and supervision of its employees. The director can also serve as the activities director if they meet the qualifications for that position.

(b) The director shall assign himself, the activities director, registered nurse or therapist to act as adult day health care coordinator for each participant and shall document in the participant's file the identity of the care coordinator. The adult day health care coordinator shall be responsible for management of the participant's plan of care and for its review with the program aides.

(c) The director shall meet the qualifications specified in the DSS standards for adult day health care for directors.

(2) Program aides who shall be responsible for overall care and maintenance of the participant (assistance with activities of daily living, social/recreational activities, and other health and therapeutic-related activities). Each program aide hired by the provider shall be screened to ensure compliance with qualifications required by DMAS. The aide shall, at a minimum, have the following qualifications:

(a) Be at least 18 years of age or older;

(b) Be able to read and write in English to the degree necessary to perform the tasks expected;

(c) Be physically able to do the work;

(d) Have satisfactorily completed an educational curriculum related to the needs of the elderly and

disabled, consistent with DMAS requirements. Documentation of successful completion shall be maintained in the aide's personnel file and be available for review by DMAS staff who are authorized by DMAS to review these files. Prior to assigning a program aide to a participant, the ADHC shall ensure that the aide has satisfactorily completed an approved training program.

(3) A registered nurse (RN) employed or contracted with the center who shall be responsible for administering to and monitoring the health needs of the participants. The nurse shall be responsible for the planning and implementation of the plan of care involving multiple services where specialized health care knowledge is needed. The nurse shall be present a minimum of eight hours each month at the center. DMAS may require the nurse's presence at the adult day health care center for more than this minimum standard depending on the number of participants in attendance and according to the medical and nursing needs of the participants. Although DMAS does not require that the registered nurse be a full-time staff position, there shall be a registered nurse available, either in person or by telephone, to the center's participants and staff during all times that the center is in operation. The registered nurse shall:

(a) Be registered and licensed as a registered nurse to practice nursing in the Commonwealth; and

(b) Have two years of related clinical experience, which may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, nursing facility, or as an LPN.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Virginia Department of Social Services is responsible for the verification of provider qualifications for Adult Day Health Care, according to Virginia Administrative Code requirements for licensing. Provider qualification verifications for ADHC providers reimbursed through DMAS FFS are conducted by the DMAS Provider Enrollment Unit. The Provider Enrollment unit verifies the additional requirements set forth in the Virginia Administrative Code that are in addition to the licensing requirements. Additionally, provider qualifications are verified during Quality Management Reviews (QMR).

Cardinal Care
MCOs are responsible for provider qualification verifications. Additionally, providers enrolled with MCOs are required to complete the credentialing process as specified in the MCO's contract with DMAS. The credentialing process is conducted in accordance with standards as outlined by NCQA for network development and maintenance.

Frequency of Verification:

Providers of Adult Day Health Care are subject to a scheduled licensing review and renewal, depending on the type of license issued. For providers reimbursed through DMAS FFS, the Provider Enrollment Unit verifies provider qualifications initially and every five years.

Cardinal Care
Providers are re-credentialed by the MCO in accordance with NCQA standards which is at a minimum of every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Assistance Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Personal assistance services include assistance with Activities of Daily Living (ADL): eating, bathing, dressing, transferring, and toileting, including medication monitoring and monitoring of health status and physical condition. This service does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated pursuant to the Virginia Administrative Code 18VAC90-19-240 through 18VAC90-19-280. When specified in the service plan, personal assistance services may include assistance with Instrumental Activities of Daily Living (IADL), such as dusting, vacuuming, shopping, and meal preparation, but does not include the cost of meals themselves. Assistance with IADLs must be essential to the health and welfare of the individual, rather than the individual's family. Personal assistance services may include access to the community, monitoring of health status and physical condition, and general supervision when the individual is unable to be left alone. These services substitute for the absence, loss, diminution, or impairment of a physical, behavioral, or cognitive function.

An additional component to personal assistance is work-related or school-related personal assistance. This allows the personal assistance provider to offer assistance and supports for individuals in the workplace and for those individuals attending post-secondary educational institutions. This service is only available to individuals who require personal assistance services to meet their ADLs. Workplace or school supports through the CCC Plus Waiver are not provided if they are services provided by the Department of Aging and Rehabilitative Services, required under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act of Section 504 of the Rehabilitation Act.

Personal assistance services support individuals in the community and allows them to avoid institutionalization.

Individuals are afforded the opportunity to act as the employer in the self-direction of personal assistance services. This involves hiring, training, supervision, and termination of self-directed personal assistants.

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

Personal assistance hours are limited to 56 hours per week, 52 weeks per year, for a maximum total of 2,920 hours per year. The Department shall provide for individual exceptions to this limit using criteria based on dependency in activities of daily living, level of care, and taking into account the risk of institutionalization if additional hours are not provided. When a legally responsible individual is paid to provide personal care, the legally responsible individual is limited to provide 40 hours per week of paid personal care.

This service is not a replacement of PDN services performed by the RN. Personal assistance services may not be provided concurrently with private duty nursing services.

Personal assistance aides may not provide supervision to individuals with skilled needs (not allowed under delegation) which requires professional nursing judgment.

The services under the Commonwealth Coordinated Care Plus Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Consumer Directed personal assistants who are eligible for overtime under the Fair Labor Standards Act are permitted to work up to 56 hours per work week for their employer (waiver participant). A legally responsible individual who provides the service to their spouse or minor child are permitted to work up to 40 hours per work week for their employer (waiver participant) as described in C-2-d. The limit in C-2-d also applies to agency directed personal care aides hired through a personal care agency when the aide is a legally responsible individual to the person for whom he/she is providing paid care.

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 Agency
Individual	Consumer Directed Personal Assistant

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistance Services

Provider Category:

Agency

Provider Type:

Personal Care Agency

Provider Qualifications

License *(specify):*

Personal care agencies must be licensed by the Virginia Department of Health or have accreditation from any organization recognized by the CMS for the purposes of Medicare certification.
Licensing requirements for RNs and LPNs are outlined in Chapter 30 of title 54.1 of the Code of Virginia.

MCOs will be required, at minimum, to require providers in their network to meet DMAS standards for fee for service providers. Agencies must also be credentialed through MCOs.

Certificate *(specify):*

Other Standard *(specify):*

The provider agency must employ (or subcontract with) and directly supervise a registered nurse who will provide ongoing supervision of all personal care assistants. The registered nurse must be currently licensed to practice in the Commonwealth of Virginia and meet Virginia Department of Health requirements. Documentation of both license and clinical experience must be maintained in the provider agency's personnel file for review by DMAS staff. There must also be documentation of a positive work history, as evidenced by at least two satisfactory reference checks recorded in the nurse's personnel file. A copy of the nurse's current license must be on file in the personnel record.

Qualifications for individuals who provide personal assistant services through an agency include:

1) Physical ability to do the work;
2) Ability to read and write English to the degree necessary to perform the required tasks;
3) Completion of a minimum 40-hour training curriculum;
4) Submit to a criminal history record check and submit to a record check under the State's Child Protective Services Registry, which verifies that the personal assistant has not been convicted of crimes described in the Code of Virginia 32.1-162.9:1.

Fee for Service agencies must possess a Provider Participation Agreement with the Department of Medical Assistance Services.

MCOs will be required, at minimum, to require providers in their catchment area to meet DMAS standards for fee for service providers. Agencies must also be credentialed through MCOs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Personal care services agencies must employ personal care assistants that meet the specified qualifications and demonstrate such to the Virginia Department of Medical Assistance Services via the Provider Enrollment Unit, during the QMR process, and by the Virginia Department of Health during licensure review.

MCOs will be responsible for verifying qualifications of providers in their network.

Frequency of Verification:

Provider qualifications are verified initially and every five years, and during the QMR process.

Providers are re-credentialed by the MCO in accordance with NCQA standards which is at a minimum of every three years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistance Services

Provider Category:

Individual

Provider Type:

Consumer Directed Personal Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The consumer directed personal care assistant must:

1) Be 18 years of age or older;
2) Possess basic reading, writing, and math skills and be able to read and write English to the degree necessary to perform the required tasks;
3) Have a valid Social Security Number;
4) Have the required skills to perform consumer-directed personal assistance services identified in the individual's service plan;
5) Submit to a criminal history record check and when providing services to a minor, submit to a record check under the State's Child Protective Services Registry, which verifies that the personal assistant has not been convicted of crimes described in the Code of Virginia 32.1-162.9:1;
6) Be willing to attend training (i.e. safety training) at the request of the individual or family/caregiver;
7) Receive periodic tuberculosis screenings;
8) Understand and agree to comply with the consumer-directed personal assistance services requirements.

MCOs will be required, at minimum, to require this provider to meet DMAS standards for the FFS system.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracted fiscal employer agent is responsible for the verification of consumer-directed personal assistant qualifications for both FFS and MCOs. The verification process is monitored by the Department of Medical Assistance Services.

Frequency of Verification:

Provider qualifications are verified initially and upon changes in employment, and during the QMR process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Care Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09011 respite, out-of-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Respite care services are provided to individuals unable to care for themselves and are furnished on a short-term basis because of the absence or need for relief of those primary unpaid caregivers who normally provide care. Respite care services may be provided in the individuals home or place of residence or in a children's residential respite facility.

Respite service may include skilled nursing care.

Individuals are afforded the opportunity to act as the employer in the self-direction of respite care services with the exception of those requiring skilled nursing respite services. This involves hiring, training, supervision and termination of self-directed care assistants. Individuals choosing to receive services through the CD model may do so by choosing a services facilitator to provide training and guidance needed to be an employer. If the individual is unable to independently manage his/her own CD services, or if the individual is under 18 years of age, a spouse, guardian, adult child or parent of a minor child must serve as the employer on behalf of the individual. Consumer direction is not available to individuals receiving skilled respite services or PDN due to the complex medical needs of the population.

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

Respite care services provided in any setting are limited to a total of 480 hours per recipient per state fiscal year (7/1 - 6/30).
Individuals who receive personal care from a legally responsible individual (spouse or parent of the minor waiver individual). shall not be authorized for the respite service, since the legally responsible individual, as primary caregiver, is paid.

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	Consumer Directed Respite Care Assistant
Agency	Children's Residential Facility
Agency	Personal Care Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:
Individual
Provider Type:

Consumer Directed Respite Care Assistant
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The consumer-directed respite care assistant must:

1) Be 18 years of age or older;
2) Possess basic reading, writing, and math skills and be able to read and write English to the degree necessary to perform the required tasks;
3) Have a valid Social Security Number;
4) Have the required skills to perform consumer-directed respite care services identified in the individual's plan of care;
5) Submit to a criminal history record check, and when providing services to a minor child submit to a record check under the State's Child Protective Services Registry, which verifies that the personal assistant has not been convicted of crimes described in the Code of Virginia 32.1-162.9:1;
6) Be willing to attend training (i.e. safety training) at the request of the individual or family/caregiver;
7) Receive periodic tuberculosis screenings;
8) Understand and agree to comply with the consumer-directed respite care services requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracted FE/A is responsible for the verification of consumer-directed respite care assistant qualifications for both FFS and MCOs. The verification process is monitored by the Department of Medical Assistance Services.

Frequency of Verification:

Provider qualifications are verified initially and during the QMR process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

Children's Residential Facility

Provider Qualifications

License *(specify):*

The Children's Residential Facility must be licensed by the Department of Behavioral Health and Developmental Services as a Children's Residential Facility as a respite provider for children with Intellectual Disability.

Certificate *(specify):*

Other Standard *(specify):*

MCOs at a minimum must require providers in their network to meet DMAS standards and requirements for FFS. Additionally, participating agencies must be credentialed by the MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDS Office of Licensing verifies that Children's Residential Facilities meet the licensing standards. DMAS verifies qualifications initially and periodically during licensure renewal.

Cardinal Care
MCOs are responsible for provider qualification verifications. Additionally, providers enrolled with MCOs are required to complete the credentialing process as specified in the MCO's contract with DMAS. The credentialing process is conducted in accordance with standards as outlined by NCQA for network development and maintenance.

Frequency of Verification:

DMAS will verify provider qualifications initially, every five years, and through the QMR process.

DBHDS Office of Licensing staff may conduct unannounced onsite reviews of licensed providers at any time and at least annually to determine compliance with licensing regulations.

Cardinal Care
Providers are re-credentialed by the MCO in accordance with NCQA standards which is at a minimum of every three years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

Personal Care Agency

Provider Qualifications

License *(specify):*

Personal care agencies must be licensed by the Virginia Department of Health or have accreditation from any organization recognized by the CMS for the purposes of Medicare certification.
Licensing requirements for RNs and LPNs are outlined in Chapter 30 of title 54.1 of the Code of Virginia.

Frequency of Verification:
Provider qualifications are verified initially and periodically during licensure renewal and during the QMR process.

The MCO will, at a minimum, be required to require providers in their catchment area to meet DMAS standards for FFS. Agencies must be credentialed through the MCO.

Certificate *(specify):*

Certified Nursing Assistant, Geriatric Assistant, or Home Health Assistant

Other Standard *(specify):*

The provider agency must employ (or subcontract) and directly supervise a registered nurse who will provide ongoing supervision of all personal care assistants. The registered nurse must be currently licensed to practice in the Commonwealth of Virginia and have at least two years of related clinical experience as a registered nurse. Virginia Department of Health licensure requirements must be met. Documentation of both license and clinical experience must be maintained in the provider agency's personnel file for review by DMAS staff. There must also be documentation of a positive work history, as evidenced by at least two satisfactory reference checks recorded in the nurse's personnel file. A copy of the nurse's current license must be on file in the personnel record.

Qualifications for individuals who provide respite care services through an agency include:

1) Physical ability to do the work;
2) Ability to read and write English to the degree necessary to perform the required tasks;
3) Completion of a minimum 40-hour training curriculum;
4) Submit to a criminal history record check and submit to a record check under the State's Child Protective Services Registry, which verifies that the personal assistant has not been convicted of crimes described in the Code of Virginia 32.1-162.9:1.

Agencies must possess a Provider Participation Agreement with the Department of Medical Assistance Services.

The MCO will, at a minimum, be required to require providers in their network to meet DMAS standards for FFS. Agencies must be credentialed through the MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

Respite care services agencies must employ respite care assistants that meet the specified qualifications and demonstrate such to the Virginia Department of Medical Assistance Services via the Provider Enrollment Unit, during the QMR process, and by the Virginia Department of Health during licensure reviews.

Cardinal Care
MCOs are responsible for provider qualification verifications. Additionally, providers enrolled with MCOs are required to complete the credentialing process as specified in the MCO's contract with DMAS. The credentialing process is conducted in accordance with standards as outlined by NCQA for network development and maintenance.

Frequency of Verification:

Provider qualifications are verified initially and every five years, and during the QMR process.

Cardinal Care
Providers are re-credentialed by the MCO in accordance with NCQA standards which is at a minimum of every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Services Facilitation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services facilitation is a function that assists the individual (or the individual's family or representative, as appropriate) in arranging for, directing, and managing their own waiver services. Serving as the agent of the individual or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs, accessing identified supports and services, and training the individual/family to be the employer. Practical skills training is offered to enable families and individuals to independently direct and manage their waiver services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that individuals understand the responsibilities involved with directing their services. The extent of the assistance furnished to the individual or family is specified in the service plan. This service does not duplicate other waiver services.

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	Services Facilitator

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Services Facilitation

Provider Category:

Agency

Provider Type:

Services Facilitator

Provider Qualifications

License *(specify):*

A SF that is a registered nurse must be licensed by the Board of Nursing.

Certificate *(specify):*

Other Standard *(specify):*

All services facilitators must complete the DMAS-approved consumer-directed services facilitator training course and pass the corresponding competency assessment with a score of at least 80%. The course must be completed with a passing score of at least 80% for each competency assessment every five years.

MCOs at a minimum must require providers in their network to meet DMAS standards and requirements for FFS. Additionally, participating agencies must be credentialed by the MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMAS verifies qualifications of services facilitators through the Provider Enrollment Unit.

Cardinal Care
MCOs are responsible for provider qualification verifications. Additionally, providers enrolled with MCOs are required to complete the credentialing process as specified in the MCO's contract with DMAS. The credentialing process is conducted in accordance with standards as outlined by NCQA for network development and maintenance.

Frequency of Verification:

Provider qualifications are verified initially and every five years, and during the QMR process.

Cardinal Care
Providers are re-credentialed by the MCO in accordance with NCQA standards which is at a minimum of every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

"Assistive Technology" is specialized medical equipment, supplies, devices, controls, and appliances not available under the State Plan for Medical Assistance, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or which are necessary to their proper functioning. Assistive technology devices must be portable.

The equipment and activities are:
1) Specialized medical equipment, ancillary equipment, and supplies necessary for life support not available under the State Plan for Medical Assistance;
2) Durable or nondurable medical equipment and supplies (DME) not available under the State Plan for Medical Assistance;
3) Adaptive devices, appliances, and controls not available under the State Plan for Medical Assistance which enable an individual to be more independent in areas of personal care and activities of daily living; and
4) Equipment and devices not available under the State Plan for Medical Assistance, which enable an individual to communicate more effectively.

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

Limit
This service must be service-authorized. It is limited to $5,000 per year and may not duplicate any same plan year.

The services under the Commonwealth Coordinated Care Plus Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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	Assistive Technology Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Assistive Technology Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A provider may either expand its current DMAS Participation Agreement or MCO provider agreement to provide Assistive Technology or obtain a Durable Medical Equipment (DME) Provider Agreement with DMAS or the MCO. DMAS and MCOs contract directly with DME providers which routinely provide specialized medical equipment and supplies in accordance with the Virginia State Plan for Medical Assistance. Providers that supply assistive technology for an individual may not perform assessment/consultation, write specifications, or inspect the assistive technology for that individual. Providers of services may not be spouses or parents of the individual. Assistive technology must be delivered with the service authorization dates in the service plan time frame.

MCOs at a minimum must require providers in their network to meet DMAS standards and requirements for FFS. Additionally, participating agencies must be credentialed by the MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMAS verifies provider qualifications through the Provider Enrollment Unit.

Cardinal Care
MCOs are responsible for provider qualification verifications. Additionally, providers enrolled with MCOs are required to complete the credentialing process as specified in the MCO's contract with DMAS. The credentialing process is conducted in accordance with standards as outlined by NCQA for network development and maintenance.

Frequency of Verification:

DMAS verifies qualifications initially and every five years and periodically during QMR.

Cardinal Care
Providers are re-credentialed by the MCO in accordance with NCQA standards which is at a minimum of every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Environmental modifications are physical adaptations to an individual's primary residence and/or primary vehicle used by the individual, which provide direct medical or remedial benefit to the individual, and are required by the participant's service plan. These adaptations are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home. All services shall be provided in accordance with applicable state or local building codes.

The modifications and activities are:
1) Physical adaptations to a house or place of residence necessary to ensure an individual's health or safety, e.g., installation of specialized electric and plumbing systems to accommodate medical equipment and supplies.
2) Physical adaptations to a house or place of residence that enable an individual to live in a non-institutional setting and to function with greater independence, i.e., grab bars, widening of doorways, modifications of bathroom facilities.
3) Modifications to the primary vehicle being used by the waiver individual, including repairs only to those modifications.

Home accessibility adaptations cannot be provided to adapt living arrangements that are owned or leased by providers of waiver services.

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

Environmental modifications shall be covered in the least expensive, most cost effective manner. They are limited to $5,000 per year and cannot increase the square footage of the place of residence except when necessary to complete an adaptation. The service does not cover the purchase, leasing, or general repairs of the primary vehicle used by the individual. Regular and general maintenance of the vehicle is not permissible. All modifications must be service authorized by DMAS and its contractor. This service cannot duplicate any modifications provided in the same plan year. The date of the service claim must be within the prior authorization dates, which may be prior to the delivery date as long as the initiation of services commenced during the approval dates.

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 Modification Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

Environmental Modification Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must have a current DMAS Participation Agreement to provide environmental modifications as a durable medical equipment provider. DMAS will permit only a provider to bill for Medicaid reimbursement for environmental modifications provided by individuals or companies contracted by the provider to make the necessary modifications.

The contractor must:
1) Comply with all applicable state and local building codes;
2) If used previously by the provider, have satisfactorily completed previous environmental modifications; and
3) Be available for any service or repair of the environmental modifications.
Providers may not be spouses or parents of the individual. Modifications must be completed within the service plan time frame.

It is possible that the services of any or all of the following four professions may be required to complete one modification:
1) A Rehabilitation Engineer;
2) A Certified Rehabilitation Specialist;
3) A building contractor; or
4) A vendor who supplies the necessary materials.
MCOs at a minimum must require providers in their network to meet DMAS standards and requirements for FFS. Additionally, participating agencies must be credentialed by the MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMAS verifies qualifications via the Provider Enrollment Unit.

Cardinal Care
MCOs are responsible for provider qualification verifications. Additionally, providers enrolled with MCOs are required to complete the credentialing process as specified in the MCO's contract with DMAS. The credentialing process is conducted in accordance with standards as outlined by NCQA for network development and maintenance.

Frequency of Verification:

DMAS verifies qualifications initially, every five years and periodically through the QMR process.

Cardinal Care
Providers are re-credentialed by the MCO in accordance with NCQA standards which is at a minimum of every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System (PERS)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time. When medically appropriate, the PERS device can be combined with a medication monitoring system to monitor medication compliance.

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 Emergency Response System Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:

Agency

Provider Type:

Personal Emergency Response System Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A PERS provider may be a certified home health or personal care agency, a long-term home health care program, a hospital, or any other entity capable of providing PERS services either directly or through subcontracts.

A PERS provider may also be a monitoring agency that is capable of receiving signals for help from an individual's PERS equipment 24 hours per day, seven days per week; determining whether an emergency exists; and notifying an emergency response organization or an emergency responder that the PERS individual needs emergency help.

A PERS provider must comply with all applicable Virginia statutes and all applicable regulations of DMAS and all other governmental agencies having jurisdiction over the services to be performed.

The PERS provider has the primary responsibility to furnish, install, maintain, test, and service the PERS equipment as required, as well as to appropriately respond to signals for help.
a) The PERS provider must properly install all PERS equipment into a PERS individual's functioning telephone line and must furnish all supplies necessary for installing this equipment;
b) A PERS provider must maintain all installed PERS equipment in proper working order;
c) A PERS provider must maintain a data record for each PERS individual at no additional cost to DMAS;
d) The PERS provider must provide an emergency response center staffed with trained emergency response operators available on a 24-hour basis, 365 days per year. The PERS provider must ensure that the monitoring agency is able to respond to the individual when an individual signals for help.

Standards for Monitoring Agencies. Monitoring agencies must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It is the PERS provider's responsibility to assure that the monitoring agency and the agency's equipment meet all requirements. The agency must ensure 24 hour staffing of the monitoring agency and ensure that monitoring agency staff is fully trained regarding responsibilities when the monitoring agency receives signals for help from an individual's PERS equipment. The monitoring agency staff will pass a written test administered by the provider pertaining to proper operation of the system and response to emergencies prior to being assigned to the agency.

MCOs at a minimum must require providers in their network to meet DMAS standards and requirements for FFS. Additionally, participating agencies must be credentialed by the MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Virginia Department of Medical Assistance Services via the Provider Enrollment Unit is responsible for the verification of provider qualifications.

Cardinal Care
MCOs are responsible for provider qualification verifications. Additionally, providers enrolled with MCOs are required to complete the credentialing process as specified in the MCO's contract with DMAS. The credentialing process is conducted in accordance with standards as outlined by NCQA for network development and maintenance.

Frequency of Verification:

Verification of provider qualifications occurs initially and every five years.

CCC and CCC+
Providers are re-credentialed by the MCO in accordance with NCQA standards which is at a minimum of every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Private Duty Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Private duty nursing services consist of individual and continuous care (in contrast to part-time or intermittent care) provided by licensed nurses within the scope of the State's Nurse Practice Act. These services are provided to an individual at home or in a community setting (school.) Services provided to more than one individual in the home will be reimbursed as congregate private duty nursing services where the maximum ratio of nurse to recipient will be 1:2. Private duty nursing services are necessary to prevent institutionalization.

Private duty nursing services are available to individuals who meet one of the following criteria:
An individual must be chronically ill or severely impaired and require both a medical device to compensate for the loss of a vital body function and substantial ongoing nursing care to avert death or further disability. The requirement for a medical device to compensate for the loss of a vital body function may include one or more of the following categories.

* Individuals dependent at least part of each day on mechanical ventilators, and
* Individuals meeting specialized tracheotomy criteria.

The need for substantial and ongoing nursing is determined by the score an individual receives on the Objective Scoring Tool. Individuals must score a minimum 50 in the Technology section of the tool to receive services.

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

Private duty nursing is provided up to 112 hours per week and the family assumes responsibility for all care for the rest of the day. This is included but not limited to when the provider agency is unable to provide private duty nursing services. Medicaid reimbursement is not provided for parents(natural/adoptive/legal guardians), spouses, siblings, grandparents, grandchildren, adult children or legal guardians or any other person living under the same roof shall not be reimbursed for Medicaid skilled private duty nursing services. Services may be provided to no more than three waiver individuals in the home at the same time.

The services under the Commonwealth Coordinated Care Plus Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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	Private Duty Nursing Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

Private Duty Nursing Agency

Provider Qualifications

License *(specify):*

Private Duty Nursing Agencies must be licensed as a home health agency by the Virginia Department of Health.

Certificate *(specify):*

Other Standard *(specify):*

Employ nursing staff that are either licensed as a practical nurse (under direction of a RN) or a registered nurse with a current and valid Virginia license. Each LPN and RN must demonstrate specialized proficiency with delivery of nursing care to any population which has specialized needs, e.g., a ventilator-dependent individual, prior to assignment to such an individual. Each LPN and RN must demonstrate specialized experience and proficiency with delivery of nursing care to any population which has specialized needs, e.g., a ventilator-dependent individual, prior to assignment to such an individual. Each LPN and RN must meet one of the following requirements: have at least six months of intensive or specialized care experience or successfully complete a comprehensive training program designed to provide intensive or specialized care training and experience.

DMAS has identified stipulated elements that will be required in an appropriate training program. Training must include the following subject areas as related to care being provided: Anatomy and Physiology, Frequently Used Medications, Emergency Management, and Operation of Equipment. During on-site quality reviews by DMAS training documents will be examined to ensure that requirement are met.

Documentation of the private duty nurse's knowledge, skills, and experience in the care of the individuals with special needs and current CPR certification and annual T.B. test must be included in the nurse's personnel file.

Providers must also have a criminal background record check.

MCOs at a minimum must require providers in their network to meet DMAS standards and requirements for FFS. Additionally, participating agencies must be credentialed by the MCO.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMAS verifies qualifications via the Provider Enrollment Unit

Cardinal Care
MCOs are responsible for provider qualification verifications. Additionally, providers enrolled with MCOs are required to complete the credentialing process as specified in the MCO's contract with DMAS. The credentialing process is conducted in accordance with standards as outlined by NCQA for network development and maintenance.

Frequency of Verification:

Verifications are performed initially, every five years, and periodically through the QMR process.

Cardinal Care
Providers are re-credentialed by the MCO in accordance with NCQA standards which is at a minimum of every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

specified in statute.

Service Title:

Transition Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Transition services are non-recurring set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

Allowable costs include:
a. Security deposits that are required to obtain a lease on an apartment or home;
b. Essential household furnishings (e.g., bed, chair, dining table and chairs, eating utensils, food preparation items, telephone, window coverings) and appliances (e.g., washer, dryer, microwave, refrigerator, stove) that do not convey with the home or apartment;
c. Moving expenses required to occupy and use a community domicile;
d. Set-up fees or deposits for utility or service access (e.g., telephone, electricity, heating, water);
e. Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy;
f. Fees to obtain a copy of a birth certification or an identification card or drivers license; and
g. Activities to assess need, arrange for and procure needed resources.
Transition services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, are clearly identified in the service plan, and the person is unable to meet such expense or when the services cannot be obtained from another source. Transition services do not include monthly rental or mortgage expenses; food; regular utility charges; and/or household items that are intended for purely diversional/recreational purposes. This service does not include services or items that are covered under other waiver services such as chore, homemaker, environmental modifications and adaptations, or specialized supplies and equipment.

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

Services are available for one transition per individual. The total cost of these services shall not exceed $5,000, per-person lifetime limit coverage of transition costs, and must be utilized within a specified nine-month period to provide assistance with transition expenses.

This service is not available under the waiver to individuals under Cardinal Care. Rather, all managed care networks under Cardinal Care provide transition coordination and transition services as part of their holistic coverage to all individuals who seek to move from a nursing facility to the community.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transition Coordinator

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Services

Provider Category:

Agency

Provider Type:

Transition Coordinator

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

In addition to meeting the general conditions and requirements for home and community-based care participating providers, transition coordinators must meet the following qualifications:

1. Transition coordinators must be employed by one of the following: a local government agency, a private, non-profit organization qualified under section 26 U.S.C. 501(c)(3), or a fiscal management services agency with experience in providing this service.

2. A qualified transition coordinator must possess a combination of relevant work experience in human services or health care and relevant education that indicates the individual possesses the following knowledge, skills, and abilities at entry level. These must be documented on the transition coordinators job application form or supporting documentation, or observable in the job or promotion interview.

3. Transition coordinators must have knowledge of aging and the impact of disabilities; be able to conduct individual assessments (including psychosocial, health, and functional factors) and their uses in service planning; have knowledge of interviewing techniques, individuals rights, local human and health service delivery systems, including support services and public benefits eligibility requirements, principles of human behavior and interpersonal relationships; be able to communicate effectively both orally and in writing; and have knowledge of interpersonal communication principles and techniques, general principles of file documentation, and the service planning process and the major components of a service plan.

4. Transition coordinators must have skills in negotiating with individuals and service providers; observing, filling, and reporting behaviors; identifying and documenting an individuals needs for resources, services and other assistance; identifying services within the established services system to meet the individuals needs; coordinating the provision of services by diverse public and private providers; analyzing and planning for the service needs of the individual; and assessing individuals using DMAS authorized assessment forms.

5. Transition coordinators must have the ability to demonstrate a positive regard for individuals and their families or designated guardian; be persistent and remain objective; work as a team member, maintaining effective inter- and intra-agency working relationships; work independently, performing position duties under general supervision; communicate effectively, both verbally and in writing; develop a rapport and to communicate with different types of persons from diverse cultural backgrounds, and interview.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMAS verifies qualifications via the Provider Enrollment Unit.

Frequency of Verification:

Provider qualifications are verified initially and every five years, and during the QMR process.

Appendix C: Participant Services

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

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

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

Check each that applies:

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

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

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

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

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

FFS
For participants not yet enrolled in the Cardinal Care program, the service providers conduct case management functions on behalf of the waiver participants.

Cardinal Care
Care coordination is provided to individuals enrolled in the Cardinal Care program. The service is provided by the MCO to provide individualized support to program participants.

Appendix C: Participant Services

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

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

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

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

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

Positions that are required to receive a criminal history check are:
Personal Assistants--Agency and Consumer-Directed
Respite Care Assistants--Agency and Consumer-Directed
Adult Day Health Care Workers
Registered Nurse
Services Facilitators
Licensed Practical Nurse

The scope of the investigation includes a Virginia State Police Criminal History Records Check. All agency providers licensed by the Virginia Department of Health must demonstrate that criminal records checks have been completed as a part of the annual licensing process. All agency providers must also demonstrate the completion of criminal records checks as a part of the enrollment process for a DMAS Provider Participation Agreement. For consumer- directed services, the contracted Fiscal Employer Agent (FE/A)is responsible for conducting criminal records checks for attendants and this process is ensured by the DMAS Contract Monitor. Staff records are reviewed for an appropriate criminal history check as part of the Quality Management Review (QMR) process

DMAS requires that criminal background checks be requested to the Virginia State Police prior to the start of employment with additional supervision provided to the employee until the records check results are received, typically within 30 days.

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):

The Virginia Department of Social Services maintains a Child Protective Services Abuse Registry. Screenings via this registry must be completed for Personal Care Assistants and Respite Care Assistants providing care to children.

All agency providers licensed by the Virginia Department of Health must demonstrate that CPS registry checks have been completed as a part of the annual licensing process. All agency providers must also demonstrate the completion of CPS registry checks as a part of the enrollment process for a DMAS Provider Participation Agreement. For consumer-directed services, the contracted FE/A is responsible for conducting CPS registry checks for attendants working with minor children and this process is ensured by the DMAS Contract Monitor.

DMAS requires that CPS registry checks be requested prior to the start of employment with additional supervision provided to the employee until the records check results are received, typically within 30 days.

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or

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

- ○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ◉ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

Legally responsible individuals (LRIs) may provide personal assistance services. Legally responsible individuals are defined as parents or legal guardians of minors or the participant's spouse. Personal assistance services provided by a legally responsible individual must be extraordinary in nature, which is above and beyond what they are obligated to provide. Personal assistance may only be used to meet the exceptional needs of the participant under the age of 18 due to his or her disability, and it is above and beyond the typical basic care for a child that all families with children may experience. For individuals younger than 18 years of age, the LRI must meet the needs of the participant, including the need for assistance and supervision typically required for children at various stages of growth and development.

Reimbursement may be made to LRIs for up to 40 hours per week. When the LRI is reimbursed to provide assistance for multiple children, they may be reimbursed for up to 40 hours per week for each child.

The LRI must also meet the same requirements as other personal care aides or attendants. LRIs convicted of a barrier crime, as defined in the Code of Virginia, are ineligible to be paid providers of services. All services rendered by a paid LRI must be within the scope of the personal assistance service and are limited to support with Activities of Daily Living (ADLs). Instrumental Activities of Daily Living (IADLs) and general supervision are not considered extraordinary care. A Registered Nurse must delegate skilled tasks in accordance with the Virginia Administrative Code 18 VAC 90-19-240 et seq. and Code of Virginia § 54.1-3001(12). Further, respite is not available when there is a paid LRI, as respite is for the relief of the unpaid primary caregiver.

Provider agency supervisors and CD services facilitators have oversight responsibility to ensure that services are being rendered according to the Plan of Care and that billing only occurs for services rendered. Further, DMAS Quality Management Review staff will compare documentation of service delivery with the individual's Plan of Care and compare these against payments made to ensure payments are made only for services rendered.

The RN agency supervisor/CD services facilitator and MCO care coordinator/CSB case manager must monitor the situation to ensure that the individual's growth towards independence is not hindered by having a LRI as a paid support person and that the LRI remains aware that there is a different relationship once he/she becomes a paid employee to support the individual.

When the consumer-direction model is used, the Employer of Record (EOR), who is responsible for the direct oversight of services and approves all attendant work shifts for payment, may be another LRI, including a parent or step-parent. Under consumer direction, the following requirements must be met to ensure the services are in the best interest of the participant and to ensure payments are made only for services rendered:

1. Individuals must choose a services facilitator;
2. An enhanced EOR participant agreement must be completed;
3. The DMAS-95 Addendum ("Questionnaire to Assess an Applicant's Ability to Independently Manage Consumer-Directed Services") must be completed and assessed prior to service authorization;
4. The LRI must document all tasks for each shift through a DMAS-approved method.

On-site, face-to-face monitoring of services by LRIs will be performed by the agency RN, Services Facilitator, or a licensed DBHDS provider agency's supervisor at least every 90 days. The state will also conduct targeted quarterly reviews at the participant's home to ensure that the LRIs are providing care in the best interest of the individual and that they meet the needs of the individual.

☒ **Self-directed**

☒ **Agency-operated**

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

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

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

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

The following services may be rendered by a relative or legal guardian (provided they meet all requirements): Personal Assistance and Respite.

Family members and legal guardians living under the same roof as the individual being served may not provide services unless there is objective written documentation as to why there are no other providers available to provide the services. This does not apply to legally responsible individuals. Family members and legal guardians who provide these services must meet the same standards as providers who are unrelated to the individual and no additional limitations exist regarding the amount of services that may be furnished by these family members or legal guardians. Examples of situations meeting the criteria of no other providers available might include:
Individuals living in a remote area unserved or underserved by other providers;
Individuals with documented complex medical or behavioral needs, which do not require skilled nursing services in nature, which are best met by the family member or legal guardian;
Individuals who require services at hard-to-staff hours;
Numerous providers have been unsuccessful at appropriately supporting the individual; or
Numerous providers have assessed the situation and responded in writing that they cannot provide services.

The information shall be documented in the individual's person-centered service plan that service delivery by the family member or legal guardian best meets the individual's preferences and support needs, and that the individual's choice of providers has been honored. Concerns that these intents will not or have not been fulfilled should be discussed with DMAS staff and/or the service plan contractor.
Provider agency supervisors (or the CD services facilitator in the case of consumer-directed services) have an oversight responsibility to ensure that services are being rendered according to the Plan of Care and that billing only occurs for documented services rendered. Further, DMAS Quality Management Review staff compare documentation of service delivery with the individual's Plan of Care and compare these against payments made to ensure payments are made only for services rendered. Both the individual's service plan contractor care coordinator and QMR staff interview individuals themselves as part of their oversight efforts and ask questions about their receipt and satisfaction with services.
If the RN agency supervisor/CD services facilitator and care coordinator does not feel that it is in the best interest of the individual for a certain family member or legal guardian to be a paid service provider, it is his/her responsibility to address this. The RN agency supervisor/CD services facilitator and care coordinator must verify that one of the above situations or another equally serious extenuating circumstance exists that necessitates a family member or legal guardian being a provider. The RN agency supervisor/CD services facilitator and care coordinator must monitor the situation to ensure that the individual's growth towards independence is not hindered by having a family member or legal guardian as a paid support person and that the family member or legal guardian remains aware that there is a different relationship once he/she is paid to support the individual.

RN agency supervisors/CD services facilitators also have recourse to the service authorization contractor (FFS) or the managed care organization (MCO) in the form of relaying their concerns. The service authorization contractor/ MCO will review the information submitted and make a determination as to whether or not authorizing a particular person as paid caregiver should or should not occur. As for all staff supporting individuals in the waiver, if a family member/legal guardian has committed a "barrier crime" as defined in Virginia Code, he or she is ineligible to be a paid provider of services.
All waiver services must be authorized prior to delivery by the service authorization contractor /MCO who will review and compare the individual's assessment information and their Plan of Care. Staff authorize services which are in compliance with regulations and in accordance with the individual's needs (inclusive of best interests). Therefore, providers may not bill for services beyond the limits which are authorized. DMAS Quality Management Review and Provider Integrity staff conduct look behinds to ensure that, for a sample of waiver participants, payment is in accord with documentation of service delivery.

○ **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:

All providers may initiate a provider enrollment application through the DMAS Medicaid Web Portal. There is no fee for provider application or enrollment. Interested providers submit an application and supporting documentation, including a Participation agreement, through the portal which is then reviewed by the DMAS Provider Enrollment Contractor. When all criteria are met, the application is processed and a provider enrollment number is issued within 10 business days. All Medicaid enrolled personal care agency providers must be licensed by the Virginia Department of Health or have accreditation from any organization recognized by CMS for the purposes of Medicare certification.

Cardinal Care
The MCOs are not required to contract with all willing providers; however, its network must meet adequacy requirements in accordance with 42 CFR §438.68, when establishing and maintaining its network

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
QP1. Number and percent of licensed/certified provider agency direct staff who have satisfactory criminal background checks. N: #licensed/certified provider agency direct staff who have criminal background checks with satisfactory results. D: total #licensed/certified provider agency direct staff records reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: 100% of staff whose names appear in the records reviewed during the QMR
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
QP2. Number and percent of new licensed/certified providers credentialed by the MCO with the appropriate license/certification as required. N: # new licensed/certified providers credentialed by the MCO with the appropriate license/certification. D: total # new licensed/certified providers credentialed by the MCO.

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

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
QP3. Number and percent of licensed/certified new waiver agency fee for service providers for which appropriate licensure/certification were obtained in accordance with requirements prior to service provision. N:# new waiver agency FFS providers meeting required licensure/certification prior to service provision D:total #new waiver agency FFS providers with licensure/certification requirements.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Medicaid Enterprise System (MES)

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

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

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

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
QP4. Number and percent of licensed/certified provider agencies continuing to meet applicable licensure/certification following initial MCO credentialing N: # licensed/certified provider agencies continuing to meet applicable licensure/certification following MCO credentialing D: total # licensed/certified provider agencies.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Quality Management Review

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

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The State 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:
QP5. Number and percent of new consumer-directed employees who have a criminal background check at initial enrollment. N: # of new consumer-directed employees who have a criminal background check at initial enrollment D: total # new consumer-directed employees enrolled.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
QP6. Number and percent of consumer-directed employees with a failed criminal background check that are barred from employment. N: # of consumer-directed employees who have a failed criminal background who are barred from employment D: total # consumer-directed employees who have a failed criminal background check.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
QP7. Number and percent of consumer-directed (CD) employers trained, as required, regarding employee management and training. N: # of CD employers trained as required regarding employee management and training. D: total # of CD employer training 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**	☐ **Weekly**	☒ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
QP8. Number and percent of new Service Facilitator, Environmental Modification, & Assistive Technology providers credentialed by the MCO or enrolled with DMAS who initially met waiver provider qualifications. N: # new SF, EM, & AT providers who initially met waiver provider qualifications. D: total # SF, EM, AT providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Provider enrollment system

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
QP9. Number and percent of fee for service licensed/certified provider agencies continuing to meet applicable licensure/certification N: # licensed/certified fee for service providers continuing to meet applicable licensure/certification D: total # licensed/certified fee for service provider agencies

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
QP10. Number and percent of services facilitation providers meeting training requirements and passing competency testing as specified in state regulation N: # of services facilitators meeting training requirements D: total # of services facilitators reviewed.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
QP11. Number and percent of provider staff meeting provider staff training requirements. N: # provider staff meeting provider staff training requirements D: total # provider staff reviewed.

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

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

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

If DMAS QMR staff or the MCO identifies problems with any of the above measures for a given provider, each deficiency will require a corrective action plan to be developed and implemented by the provider.

Individual providers with systemic problems will be targeted for technical assistance/training from DMAS or the MCO. These events and their results will be documented in quarterly reports of technical assistance.

ii. Remediation Data Aggregation

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

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

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

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

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.

The majority of services provided through the CCC Plus Waiver are delivered in the member's home with the exception of adult day health service (ADHC) which is delivered in a provider-owned setting. All individuals receiving CCC Plus Waiver services, including those receiving ADHC services, live in their own home or family home. There are no provider owned/controlled residential service options in the CCC Plus Waiver.

The state conducted setting assessments for each ADHC setting. The state first identified the settings by location and capacity. The state determined that none of the ADHC settings were identified as presumed to be institutional due to physical location. Each ADHC provider completed a web-based self-assessment developed by using the CMS exploratory questions and HCBS setting requirements. The assessment required providers to include copies of policies and procedures and photos to demonstrate the compliance with the settings rule. State staff reviewed the self-assessment to determine the compliance of the ADHC setting. Remediation plans were developed by the provider for settings that did not demonstrate full compliance. State staff was assigned to work with providers to oversee remediation actions and follow-up on-site or desk reviews. All compliance determinations went through a first and second level review to verify full compliance. As of December 20, 2017, all ADHC settings were fully compliant with the HCBS settings rule.
All new ADHC providers are required to meet the requirements of the HCBS settings rule prior to obtaining a Medicaid provider agreement or being credentialed by a MCO. To ensure this, potential ADHC providers must complete the aforementioned self-assessment. State staff review the information provided and determines compliance in the same manner as the initial self-assessments including remediation efforts. When full compliance is established, a compliance letter is provided that must be included with the Medicaid provider agreement application and the MCO application for credentialing.

The HCBS settings requirements are included in the MCO contracts. This includes ensuring that providers maintain compliance with the provisions of the settings rule as detailed in 42 CFR § 441.301(c) (4)-(5). DMAS and the MCOs continue to provide monitoring of the ADHC sites to ensure ongoing compliance with the rule, identify any compliance issues, and work with providers on remediation of areas of concern. DMAS and MCO quality staff conduct onsite and desk reviews of ADHC settings and assess continued HCBS compliance. Individual Experience Assessments are another element in monitoring the compliance of the ADHC settings. This tool is used to ascertain the experiences of members receiving ADHC services. Any areas of concern or issues identified as a result of the assessment are remediated. In addition to these strategies, DMAS is currently conducting a full re-evaluation of all ADHC settings to assess continued compliance.
In private homes, care coordinators are responsible for ensuring services and supports are provided in a manner that comports with the settings provisions of the HCBS regulations. Additionally, on-going monitoring of HCBS regulations are conducted by quality management reviewers in both managed care and fee for service. Staff review provider records and conduct participant interviews to ensure services are provided in accordance with HCBS requirements.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Plan of Care

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:

Cardinal Care
Care coordination is provided for individuals enrolled in managed care by the MCO. MCO care coordinators provide person-centered individualized support to program participants and develops the overall plan of care.

Care coordinators assigned to individuals under the waiver shall have at least a bachelor's degree in a health or human services field or be a Registered Nurse (RN) or Licensed Practical Nurse (LPN). All care coordinators shall have at least one year of experience directly working with individuals who meet the target population criteria. Licensed or Certified Care Coordinators must be licensed or certified in Virginia or hold a RN/LPN license with multi-state privilege recognized by Virginia in accordance with §54.1-3040.1 et. seq., of the Code of Virginia.

When the plan of care includes the need for private duty nursing, care coordination is provided by a registered nurse (RN) licensed to practice nursing in Virginia. or holds a RN licensed with multi-state privilege recognized by Virginia. The RN must have a minimum of one year of related clinical nursing experience with medically complex conditions including those dependent on life sustaining equipment.

For all other Members with LTSS needs (institutional and community-based), the care coordinator shall be either: (i) a RN licensed to practice nursing in Virginia with at least one year of experience as a RN; or (ii(ii) a LPN licensed to practice nursing in Virginia with at least one year experience as a LPN; or (iii) an individual who holds at least a bachelor's degree in a health or human services field and has at least one year of experience working with individuals who are elderly and/or have disabilities. Licensed or Certified Care Coordinators must be licensed or certified in Virginia or hold a RN/LPN license with multi-state privilege recognized by Virginia in accordance with 54.1-3040.1 et seq. of the Code of Virginia.

FFS
For those receiving agency-directed services, the service plan is developed by a RN licensed to practice nursing in Virginia with at least one year of experience as a RN.

For those receiving consumer-directed services, the service plan is developed by a Services Facilitator meeting the qualifications as described as follows and also as outlined in Appendix C:
Services facilitators shall possess at a minimum, either (i) an associate's degree from an accredited college in a health or human services field or be a registered nurse currently licensed to practice in the Commonwealth and possess a minimum of two years of satisfactory direct care experience supporting individuals with disabilities or older adults; or (ii) a bachelor's degree in a non-health or human services field and possess a minimum of three years of satisfactory direct care experience supporting individuals with disabilities or older adults.

☐ **Social Worker**
Specify qualifications:

☒ **Other**
Specify the individuals and their qualifications:

For FFS individuals electing to self-direct services, the Services Facilitator is responsible for service plan development.

The Services Facilitator must possess a combination of relevant education and work experience that indicates possession of the knowledge, skills, and abilities as outlined in Appendix C.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

Upon initial entry into the waiver, the screening team develops the initial person-centered service plan. After determining the individual meets the waiver criteria, the screener informs the individual of the services available in the waiver, the individual chooses the services that based on their desired needs and preferences. The screening team then presents the individual with a list of DMAS enrolled providers of the service in that locality. The individual freely chooses the service provider and a referral is made to the chosen provider. This choice is documented in the electronic Pre-Admission Screening (ePAS) system.

For members participating in the Cardinal Care managed care program, the subsequent person centered plan of care is developed by the care coordinator with collaboration from the individual and the individual's family or caregiver as appropriate. The care coordinator is employed by the MCO and is not a direct service provider. The participant freely chooses services and service providers among those participating in the MCO network. The care coordinator documents the participant's choices in the record.

For the few FFS participants exempt from Cardinal Care, the individual's service provider develops the subsequent person-centered plan of care. The provider meets with the individual (and family or caregiver, as appropriate) and develops the person-centered plan of care based on the information in the initial plan of care completed by the screening team. The individual/family/caregiver and provider also update the plan of care based on newly addressed needs and preferences. There are no other entities or individuals able to accept responsibility for service plan development. For agency-directed services, the RN supervisor develops the plan of care. For consumer-directed services, the Services Facilitator develops the plan of care. Neither the RN Supervisor nor the Services Facilitator provide direct care services to the individual. DMAS understands this presents a conflict of interest as indicated in regulations at 42 CFR 441.301(c)(1)(vi). As such, DMAS devised a solution that will mitigate the conflict of interest that is planned to be fully implemented by January 1, 2024. DMAS procured a new service authorization vendor that will be tasked with the development of the subsequent annual person-centered service plan for members who are exempt from Cardinal Care. The vendor will collaborate with the individual and the individual's family or caregiver as appropriate to develop the plan.

While the mitigation plan is being implemented, safeguards will continue to be in place to mitigate any risk of conflict of interest with providers developing service plans. All plans of care are subject to authorization by the DMAS service authorization contractor. The contractor reviews the plan for appropriateness based on the individual's level of care identified in the Uniform Assessment Instrument (UAI) and reassessments. The contractor may approve, deny, or pend request for more information. Services are not reimbursed without the appropriate authorization.

During the service plan development, if there is a disagreement between the individual/family/caregiver and the provider, the provider is instructed to accede to the desired preferences of the individual and submit the requested plan of care to the service authorization contractor. The plan of care must be documented on the DMAS 97AB and signed by the waiver participant. The document includes instructions for the participant to appeal to the DMAS agency in the event they disagree with the plan and the provider refuses to make changes. The waiver participant is also free to change service providers at any time.

Quality Management Review (QMR) conducted by DMAS provides additional monitoring and oversight of service plan development safeguards. All plans are subject to review by the Medicaid agency via the QMR to assure that services are approved, meet the needs, and are appropriate for the participant. QMR staff determine whether services delivered were appropriate, continue to be needed by the participant, and the type, amount, scope, duration, and frequency of services were necessary and delivered consistent with the service plan. Additionally, QMR staff verifies that the choice of provider and services were offered and documented in the individual's record. DMAS QMR analysts conduct a review of all documentation, which shows the participant's level of care. Visits are conducted on-site and are unannounced.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The participant and any person(s) chosen by the participant is provided with information about available waiver services initially by the screening team. During the initial level of care screening, the participant and any person(s) he/she chooses to participate is actively involved in the process of determining what services and model of service delivery are best suited to meet the participant's needs. The participant is provided options of services and providers and directly chooses those that will best meet his/her needs.

Fee for Service:
Upon receipt of the referral, a registered nurse (RN) (agency-directed services) or a services facilitator (SF) (consumer-directed services) schedules an initial assessment and works with the participant and their family or caregiver as appropriate to develop the plan of care. The participant is encouraged to include whomever he wants to participate in the process, or may elect to exclude whomever he wants. Participants may include other service providers, trusted representatives or anyone the participant chooses. This approach helps to ensure the participant's satisfaction with services, provides health and safety protections by increasing service coordination and ensuring continuity leading to optimal service delivery. The person-centered plan is developed based on the participant's identified and expressed needs and preferences. The plan is developed and the participant reviews the plan and signs that he/she agrees with it. The plan is then submitted to the service authorization contractor for approval.

After the initiation of the plan, the RN or SF makes a home visit at least every 90 days, during which, the services are discussed with the participant. Adjustments are made to the service plan with the input of the participant in the same manner as described in the initial plan.

Cardinal Care
When a participant is found to be eligible to receive waiver services by the screening team, a referral is made to the MCO informing them that the participant is in need of waiver services. The local screening team sends the LTSS packet to the MCO. The care coordinator conducts a health risk assessment and works with the participant and family to develop the person-centered Individualized Plan of Care. The care coordinator provides the participant with a list of providers available to provide services and the participant freely chooses their preferred provider. The MCO engages each participant in the Service Plan development to ensure that participants receive necessary assistance and accomodations to help make sure they are prepared and can fully participate in the planning process as well as given the opportunity to invite anyone to their care plan meetings.

Upon receipt of the referral, the chosen provider makes a face to face visit consistent with the process described above for fee for service. The Care Coordinator is responsible for being the lead and pulling together an interdisciplinary care team (ICT) based on the participant’s identified and expressed support needs and preferences. The participant is encouraged to identify and invite any person that he/she would like to participate. The holistic ICT includes health professions familiar with the participant’s support needs including medical, behavioral health, substance use, LTSS and social needs. The ICT ensures the participants supports are integrated and coordinated. The ICT provides input into the plan to ensure it is person-centered and built on the participant’s specific preferences and needs, and set up to deliver services with transparency, individualization, respect, linguistic and cultural competence, and dignity. The care coordinator facilitates the individualized care planning process, develops, and maintains the individualized care plan.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The screening team performs an initial comprehensive assessment that includes all of the participant's service needs, including non-waiver services on the Uniform Assessment Instrument (UAI) as described in Appendix B. The participant and/or participant's authorized representative, as appropriate, play an active role during this assessment and determination of the level of care required by the participant. The screening team provides information and education about services available including those available through the CCC+ waiver. Each service is discussed in detail and the participant chooses which services would best meet his/her needs. The screening team works with the participant to develop an initial plan of care that outlines the support needs, and preferences of the participant. This initial plan of care as well as the UAI is sent to the MCO or FFS provider as appropriate. If the participant is a current Cardinal Care member a referral is made to the MCO (see below for Cardinal Care processes).

FFS Process
If the participant is not enrolled in a Cardinal Care MCO, the screening team provides a list of providers and supports for the participant to make a choice of provider agency and/or consumer directed care. Upon the participant's selection of the provider, the screening team forwards all assessment and initial plan of care information to the provider(s).

The FFS service provider schedules an initial face to face assessment visit with the participant. This assessment includes an evaluation of the participant's functional status and needs, health status and needs, support system, and other service-related information. The participant is an active participant during the assessment, which also documents the participant's goals and preferences. The assessment shall be completed and documented on the Community Based Care recipient assessment form (DMAS 99). Information gathered from the assessment including input from the participant and/or the participant's authorized representative, as appropriate, is used in the development of the plan of care for each service. The plan of care takes into account the participant's health status and incorporates the participant's personal preferences regarding service delivery, as well as the participant's community support goals and provides a guideline for the number of service hours a participant will require. The plan includes the tasks to be performed and the amount of time it will take to complete the tasks.

After the plan of care is developed it is sent to the service authorization contractor for approval. The service authorization contractor reviews the proposed plan of care and the assessment to ensure it meets the participant's needs. While receiving FFS supports, the service provider is responsible for monitoring the plan of care and service provision. For those receiving agency-directed services, a RN monitors service delivery. For those choosing consumer-directed services, a Services Facilitator (SF) monitors service delivery.

The RN or SF conducts face to face visits within 30 days of the initiation of services to ensure that services are being furnished in accordance with the plan of care. The RN or SF assesses the health and safety of the participant including making sure the participant's back-up plan is effective and the participant's needs are being met. If the RN or SF finds that any area of the plan to be ineffective, they must work with the participant and/or the participant's authorized representative, as appropriate, to address the need(s). The RN or SF documents the issue(s) and the methods to address the issue(s) in the participant's record.
Waiver services and services through other means (state plan and/or other sources) are coordinated by the RN or SF and sometimes involve coordination between the RN or SF if the participant opts for a combination of agency-directed and consumer-directed supports.
Implementation responsibilities are determined when the service plan is developed.

Cardinal Care Process
For those enrolled in Cardinal Care, the screening team forwards the UAI and initial plan of care to the MCO. The MCO care coordinator facilitates the individualized care planning process, develops, and maintains the individualized care plan in partnership with the participant and/or the participant's authorized representative, as appropriate. The care planning process begins with a health risk assessment (HRA) conducted by the care coordinator. The HRA encompasses social factors (such as housing, informal supports, and employment), functional, medical, behavioral, cognitive, LTSS, wellness and preventive domains, the participant's strengths and goals, the need for any specialists, community resources used or available for the participant, and the participant's desires related to their health care needs. The HRA includes pertinent information from the UAI and discussion with the participant/representative regarding service needs. The care coordinator provides information and education about available waiver services and waiver providers. The participant chooses the services that meet his/her needs and the care coordinator provides a choice of providers. The participant chooses the providers and referrals are made by the care coordinators to the chosen providers. The care coordinator coordinates other s services (state plan services and services furnished through other state and federal program) by providing referrals and connecting the individual with state, local and other community resources.

Each service provider schedules an initial assessment consistent with the FFS process as explained above. Each plan of care is reviewed by the care coordinator and sent to the MCO service authorization entity for approval.

The plan of care is developed at the initiation of waiver services and is updated annually at a minimum or as the support needs of the participant change. Shortly after the HRA is conducted the care coordinator arranges a meeting with the interdisciplinary care team (ICT). The ICT provides input into the participant care plan and includes the participant, the participant's authorized representative, family/caregiver as appropriate, and anyone the participant would like to include. At a minimum the following professionals are invited to participate in the ICT: primary care provider, waiver service provider, Targeted Case Manager if applicable, pharmacist if indicated, and behavioral health clinician, if indicated. If the individual has an identified need for PDN services, the ICT meets within 30 days of the participant's initial enrollment with the MCO. All other individuals meet within 60 days of the participant's initial enrollment with the MCO.

The MCO care coordinator provides service coordination and ensures each provider delivers services in accordance with the individualized care plan (ICP). The care coordinator monitors and updates the plan when there is a change in the participant's circumstances. The care coordinator provides on-going monitoring of the ICP.

The MCO care coordinator performs comprehensive face to face routine re-assessments utilizing the HRA tool. Participants receiving skilled private duty nursing receive re-assessments at least every six months; all other waiver participants are re-assessed at least annually. Re-assessments are also conducted when a participant has a significant change in health or functional status or experiences a hospitalization. Upon re-assessment, the participant care plan is reviewed and adjusted to ensure the needs, goals, and preferences of the participant are being met.

The care coordinator will work with the participant to find a time that the individual agrees with to conduct service planning meetings.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Risk assessment is conducted by the screening team and again by the RN or SF. The risk assessment conducted by the RN/SF is conducted initially, during reassessment visits, and annually. The RN/SF conducts a risk assessment as part of the overall assessment prior to the development of the service plan. The RN or SF evaluates the risks and works with the participant to identify supports to mitigate the risks found and ensures that supports are sensitive to participant's needs and preferences.

Risk assessment is conducted by the RN or SF as a part of the assessment and service plan development. The RN or SF takes into account the services and supports needed as well as the supports that are already in place to mitigate risk.

For both agency-directed and consumer-directed care, the participant must have a viable back-up plan (e.g. a family member, neighbor or friend willing and available to assist the participant, etc.) in case the personal care or respite care assistant is unable to work as expected or terminates employment without prior notice. The participant/family must understand the backup plan, and it must be identified in the assessment and service plan. Upon initial enrollment, the provider works with the individual/family/caregiver to identify a viable backup plan. The RN or SF assists the participant in identifying and selecting individuals that will perform as the back-up caregiver in the event a scheduled assistant cannot provide services.

The participant is supported in selecting a variety of back up measures including, but not limited to, family supports, natural supports in the community, or additional consumer-directed employees.

Cardinal Care
The process conducted by the MCO care coordinators mirrors the FFS process. In addition, MCO care coordinators conduct health risk assessments initially, annually, and on-going as needed. Risks are evaluated by the Interdisciplinary Care team and supports are put into place to mitigate risks. The care coordinator monitors the effectiveness of the risk mitigation.

DMAS monitors and evaluates and the MCO in the service plan development process and implementation as part of the DMAS contract terms and conditions.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Participants receive a list of service providers from the screening team at the time of initial assessment and determination of eligibility and selection of community-based care. The screening team provides support to the participant in the selection of service providers by encouraging the individual and/or family member to directly contact the provider(s) to ask questions and gain information about the providers' service delivery philosophy and approach.

The RN and/or SF also assists the participant in identifying providers that best meet the needs of their needs by considering location, number of staff, complaint information, etc.

Individuals have ongoing access to information about available providers by calling DMAS or via the DMAS website. The provider search function on the website allows an individual to search by the type of service and by locality.

Cardinal Care
All CCC+ waiver participants must select from one of the contracted MCOs in six regions and use the provider network within their selected plan.

DMAS and the contracted MCOs will have outreach personnel available to assist CCC+ waiver participants and community advocates in obtaining necessary information and providing assistance in navigating through the integrated long-term care and managed care systems. Each of the MCOs maintain a provider network roster with search capabilities that can be filtered by localities served and specialty for which members have access. Participants can also contact the CCC Plus Advocate through the Office of the State Long-Term Care Ombudsman for assistance in obtaining this information.

The screening teams will be provided with enrollment packets that includes MCO information, a comparison chart that contains MCOs available in their area, information on how to access services, enrollee rights, benefits available, time frames for selection, and information on how to request a change from the Managed Care Helpline (the entity through which assignment changes must be made).

DMAS monitors the MCOs by reviewing network adequacy on a routine basis, during expansion periods, and as complaints arise. In addition, as a part of the MCO monitoring process, DMAS reviews MCO service plans to ensure provider choice was provided to CCC+ waiver participants.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The plan of care is developed by the agency RN or a consumer directed services facilitator. Plans are submitted to the service authorization contractor for review and approval. The service authorization contractor, during the review of the request, ensures that Medicaid regulatory and policy criteria are met, the services are medically necessary, and the individual's health and safety are assured. All service plans are subject to review by the Medicaid agency via the Quality Management Review (QMR) process to assure that services are approved and appropriate for the participant; however, a sampling process is employed to determine the number of records reviewed for each provider.

DMAS employs staff dedicated to the task of conducting provider quality reviews as the integral part of our Quality Management Review (QMR) process. Based on the random sampling methods described, these field staff members conduct unannounced on-site visits with providers on a daily basis.

The purpose of the Quality Management Review (QMR) is to determine whether services delivered were appropriate, continue to be needed by the participant, and the type, amount, scope, duration, and frequency of services were necessary and delivered consistent with the service plan. DMAS analysts conduct QMR of all documentation, which shows the participant's level of care, medical and functional status, and available supports, as well as the individual's satisfaction with services. Visits are conducted on-site and are unannounced.

The QMR visit is accomplished through a review of the participant's record, evaluation of the participant's medical and functional status, and consultation with the some of the waiver individuals and family/caregiver (as appropriate). Specific attention is paid to all applicable documentation, which may include service plans, RN supervisory notes, SF notes, daily logs, personal assistant time sheets, progress notes, screening packages, and any other documentation necessary to determine if appropriate services are included in the service plan and delivered accordingly.

Cardinal Care
The MCO follows processes consistent with the FFS processes. MCOs hire staff to conduct the quality management review process. DMAS maintains oversight of the MCO QMR process through contract monitors employed by DMAS. These monitors will conduct on site monitoring of MCO staff during reviews as well as desk audits of QMRs.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

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

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☒ **Other**

Specify:

Service plans are maintained by the MCO, provider agency or services facilitator. Copies of the service plans are maintained for a minimum of 6 years by the provider in FFS, or 10 years by the provider or MCO if managed care, and are located at the place of business or stored in a secure, retrievable location.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

FFS
The RN or SF must monitor service provision as often as needed and as agreed upon with the participant, but no less than every 90 days. The initial home assessment visit by the RN or SF is conducted to create the plan of care and assess the individual's needs and supports. The RN or SF must return for a follow-up visit within 30 days after the initial visit to re-assess the individual's needs and determine if the services implemented are adequate to ensure the health and welfare of the individual. The RN or SF must monitor the adequacy of the plan of care on an as needed basis, but in no event less frequently than quarterly.

Plan of care and service provision monitoring must include a review of:
* services being furnished in accordance with the plan of care;
* access of the services identified in the plan of care by the individual;
* choice of provider(s) by the waiver individual;
* individual's needs being met by services identified in the plan of care;
* back-up plan(s) availability and effectiveness;
* health, safety, and welfare of the waiver individual;
* access to services not covered by the waiver, including health care needs.

If issues with any of the above are identified by the RN or SF, it must be documented, including prompt methods for remediation, in the waiver individual's record.

Overall monitoring of service delivery and monitoring by the RN and SF are reviewed by the Department of Medical Assistance Services via Quality Management Review (QMR) and include data collection on how service plan implementation issues are monitored, identified, and reported.

Cardinal Care
The MCO is responsible for each element of the process described above for FFS. Additionally, the MCO care coordinator conducts additional monitoring activities to ensure the participant's health and safety are maintained. Care coordinators communicate with the participants at least monthly or a frequency as requested by the participant not to exceed every 90 days. Care coordinators monitor the provision of services including outcomes assessing appropriate changes or additions to services and facilitate referrals to participants when needed. Face to face visits are required at least every six months. MCOs are required to maintain community networks of resources available for participants.

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:*

For FFS participants, the individual's service provider (agency RN or SF) monitors the person-centered plan of care. There is no willing and qualified case management entity available to develop the plan of care for FFS participants. The person responsible for the monitoring the plan of care does not provide direct service for the participant. At the time of entrance into the waiver, the screening team informs the individual of the services available in the waiver, and supports the individual in choosing the services that best meets the individual's needs and preferences. The screening team works with the individual to develop an initial person-centered plan of care. The screening team then presents the individual with a list of DMAS enrolled providers of the service in that locality and explains to the individual their rights to choose any service provider. The individual freely chooses the service provider and the screening team makes the referral to the chosen provider which includes the initial plan of care. This choice is documented in the electronic Pre-Admission Screening (ePAS) system. The provider (Agency RN or services facilitator) contacts the individual and schedules a time with the individual to conduct a face to face visit. The RN/SF reviews the information provided by the screening team and conducts an assessment of the individual and identified any changes in the individual's condition. The RN/SF works with individual and any other person the individual wishes to include developing the person-centered plan of care taking into account the individual's needs, goals, and preferences. The plan of care must be documented on the DMAS 97A/B and signed by the waiver participant. The document includes instructions for the participant to appeal to the DMAS agency in the event they disagree with the plan and the provider refuses to make changes. The waiver participant is also free to change service providers at any time.

For participants not yet enrolled in Cardinal Care, the monitoring of service plan implementation and participant health and welfare are the responsibility of the provider RN or SF and are required as often as every 30 days, but at least every 90 days. Service plans may be changed as often as required to accommodate rapidly changing medical needs. Any changes in services for the participant are submitted to the service authorization contractor for review and authorization. Neither the RN or the SF provide direct care waiver services to the participant.

Quality Management Review conducted by the Department of Medical Assistance Services provides additional monitoring and oversight of service plan development and monitoring safeguards.

All service plans are subject to review by the Medicaid agency via the Quality Management Review (QMR) process to assure that services are approved, and appropriate for the individual and that the individual's needs are met. A review of the provider's service plan monitoring activities is conducted during the QMR as well. The purpose of the Quality Management Review (QMR) is to determine whether services delivered were appropriate, continue to be needed by the individual, and the amount and kind of services were required. DMAS analysts conduct QMR of all documentation, which shows the assessments service plan monitoring by the provider. Visits are conducted on-site and are unannounced.

The QMR visit is accomplished through a review of the participant's record, evaluation of the individual's medical and functional status, and consultation with the waiver individual and family/caregiver, as appropriate. Specific attention is paid to all applicable documentation, which may include service plans, RN supervisory notes, Services Facilitator notes, daily logs, personal assistant time sheets, progress notes, screening packages, and any other documentation necessary to determine if the provider is performing services as required, and in the best interests of the waiver individual.

Cardinal Care
In addition to the process described above for FFS, the MCO care coordinator conducts additional monitoring activities to ensure the participant's health and safety are maintained. The care coordinator does not provide direct care waiver services to the participant. The MCO contracts with providers to provide direct services

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

for waiver participants.

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
SP1. Number and percent of waiver individuals who have service plans that are adequate and appropriate to their needs and personal goals, as indicated in the assessment. N: # of waiver individuals records who have service plans that are adequate and appropriate to their needs and personal goals, as indicated in the assessment D: total # of waiver individuals records reviewed.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
SP2. Number and percent of individuals whose service plan was updated / revised at least annually. N: # of individuals whose service plan was updated/revised at least annually. D: Total # records reviewed

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
SP3. Number and percent of individuals whose service plan was revised as needed, to address changing needs. N: # individuals whose service plan was revised as needed, to address changing needs D: total # individual service plans reviewed where the record indicated a change in needs.

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

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

Agency		
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level and 5% confidence interval
☒ **Other** Specify: MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
SP4. Number and percent of individuals who received services of the type specified in the service plan. N: # individuals who received services of the type specified in the service plan D: total # records reviewed.

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

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

		95% confidence level and 5% confidence interval
☒ **Other** Specify: MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

SP5. Number and percent of individuals who received services in the amount specified in the service plan. N: # individuals who received amount specified in the service plan D: total # records reviewed

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

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

Data Aggregation and Analysis:

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

Performance Measure:
SP6. Number and percent of individuals who received services in the scope specified in the service plan. N: # individuals who received services in the scope specified in the service plan D: total # records reviewed

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

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

☒ **Other** Specify: MCOs	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
SP7. Number and percent of individuals who received services for the duration specified in the service plan. N: # individuals who received services for the duration, specified in the service plan D: total # records reviewed

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

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
SP8. Number and percent of individuals who received services in the frequency specified in the service plan. N: Number individuals who received services in the frequency specified in the service plan D: total # records reviewed

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

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

MCO		
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP9. Number and percent of individuals whose records documented that choice of waiver providers was provided to the individual. N: total # of records that contain documentation that choice of the waiver providers was offered to the individual D: total # of case management records reviewed.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
SP10. Number and percent of individuals whose records contain an appropriately completed and signed form that specifies choice was offered among waiver services N: total # of records that contain documentation of choice among waiver services D: total # of records reviewed.

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

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

		95% confidence level and 5% confidence interval
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

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

If DMAS QMR staff identifies problems with any of the above measures for a given provider, they each require a corrective action plan to be developed and implemented by the provider. Failure to do so jeopardizes the Medicaid provider agreement.

Individual providers with systemic problems will be targeted for technical assistance/training from DMAS. These events and their results will be documented in quarterly reports of technical assistance.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Individuals are afforded the opportunity to self-direct personal care and respite care services in the CCC+ Waiver. This Consumer Directed (CD) model of service delivery gives waiver individuals the option to choose to hire, train, supervise and terminate care assistants.

Individuals choosing to receive services through the CD model may elect the service delivery method at the time of waiver entrance or at anytime thereafter. The individual may choose to self-direct all or some of their personal care and respite care services.

The screening team provides information to the potential waiver individual about the CD model of service delivery. If the individual selects the CD model, the screening team provides a list of Services Facilitators to assist in accessing services.

The role of the Services Facilitator includes completing a comprehensive assessment of the individual, working with the individual to develop a person-centered plan of care and providing employer training. Additionally, it is the responsibility of the services facilitator to obtain authorization of services by submitting a request to the service authorization contractor.

If the individual is interested in self- direction but is unable to independently manage his/her own CD services, or if the individual is under 18 years of age, a parent of a minor child or responsible adult must serve as the employer on behalf of the individual. A person serving as the employer of record (EOR) shall not be a paid caregiver, attendant, or one's own SF.

The CD model requires the use of the Fiscal Employer Agent (FEA) contractor. The FEA conducts all payroll functions on behalf of the individual including payment of attendants, calculation and recordkeeping of paid sick leave balances, and filing of IRS wage withholdings. The FEA also requests and processes criminal background investigations on potential employees. Cardinal Care MCOs also contract with a FEA and follows the same process for participant direction employed by the state.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

- [x] **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- [x] **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- [ ] **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

- ( ) **Waiver is designed to support only individuals who want to direct their services.**
- ( ) **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- (●) **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Individuals assessed as having a cognitive disability that may limit or prevent the ability to self-direct services may designate a representative to act as the employer for self-directed care on behalf of the individual.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

The Screening Team provides information about the consumer-directed model of service delivery at the time of the initial level of care screening and service plan development. Individuals electing to self-direct services choose a Services Facilitator (SF)who is responsible for initiating services with the individual.

The SF provides support to individuals and provides the waiver individual with further information about self-direction. The SF, using the Consumer-Directed Employer of Record Manual, must provide training to the individual on the responsibilities of self-direction within seven days of completing the initial comprehensive visit. The SF must also document the training using the DMAS-488 Consumer Directed Individual Comprehensive Training Form. The SF must provide the individual/ Employer of Record a copy of the Consumer-Directed Employer of Record Manual and allow the individual time to evaluate the pros and cons of self-direction and to make a final decision. If the individual chooses to not self-direct, the SF assists the individual in transitioning to agency-directed care.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Waiver individuals have the option to appoint a person to direct care on their behalf by acting as the Employer of Record (EOR). A Consumer Direction Services Management Questionnaire (DMAS 95-Addendum) is completed by the LTSS Screening Team when the individual chooses self-direction during the initial screening phase, or the Services Facilitator if self-direction is chosen at a later date. The use of this questionnaire is intended to ensure and document that the waiver individual and the EOR have considered the responsibilities of the role and to assess that the selected person will act in the best interests of the waiver individual. The SF provides employee management training for the EOR and monitors service provision to the waiver individual. Service provision monitoring includes face to face visits no less than quarterly for consumer directed personal care and bi-annually for respite care.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Respite Care Services	☒	☐

Waiver Service	Employer Authority	Budget Authority
Personal Assistance Services	☒	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The Department of Medical Assistance Services secured financial management services for the consumer-directed model of service delivery through a competitive Request for Proposal process. DMAS holds a contract with a single fiscal employer agent (FEA). Each of the managed care organizations in Cardinal Care also contract with a fiscal employer agent to provide fiscal management services.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Payment is rendered to the FEA on a monthly billing cycle with a per member per month fee and includes all administrative functions specified in the contract between DMAS and the FEA. The percentage of FMS costs relative to the service costs is 2.4%.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☒ **Other**

Specify:

The Fiscal Employer Agent is responsible for requesting criminal background screenings of potential consumer directed employed attendants. Additionally, the FEA requests screenings from the Department of Social Services Child Protective Services Central Registry. The FEA calculates eligibility for paid sick leave for consumer-directed attendants and maintains balances of accrual and usage of the paid sick leave benefit.

Supports furnished when the participant exercises budget authority:

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

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

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

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

☐ **Other services and supports**

Specify:

Additional functions/activities:

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

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

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

☐ **Other**

Specify:

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

The Department of Medical Assistance Services employs contract monitors to oversee and assess the performance and deliverables of the Fiscal Employer Agent. Payroll system edits are required as a part of the FEA contract and the contract monitors randomly conducts system checks for financial integrity. The contractor's performance is also assessed and evaluated in a bi-annual performance review and documented on a Contract Monitoring Evaluation Form.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Respite Care Services	☐
Environmental Modifications	☐
Personal Assistance Services	☐
Assistive Technology	☐
Transition Services	☐
Private Duty Nursing	☐
Adult Day Health Care	☐
Services Facilitation	☒
Personal Emergency Response System (PERS)	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Waiver individuals may elect at any time to initiate or discontinue self-directing their care. The individual also may exercise the option of combining agency-directed and consumer-directed care in order to meet his/her service needs. In the event that an individual elects to discontinue self-direction of care, the Services Facilitator will aid the waiver individual in securing services from an agency provider.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If the Services Facilitator or Care Coordinator determines that the health, safety, and welfare of the recipient may be in jeopardy and cannot be mitigated or eliminated, the Services Facilitator will recommend to DMAS that the individual be transitioned from self-directed to agency-directed care. The care coordinator or services facilitator will aid the individual in securing services from an agency provider.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	15521	
Year 2	15821	

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 3	16121	
Year 4	16421	
Year 5	16721	

Appendix E: Participant Direction of Services

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

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

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The contracted Fiscal Employer Agent (FEA) requests and obtains criminal history checks of attendants on behalf of the self-directing waiver individual. The FEA receives reimbursement for the cost of these investigations through the claims billing process.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

The contracted Fiscal Employer Agent (FEA) requests and obtains the criminal history check of attendants on behalf of the self-directing waiver individual.

- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [ ] **Determine staff wages and benefits subject to state limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [ ] **Determine the amount paid for services within the state's established limits**
- [ ] **Substitute service providers**
- [ ] **Schedule the provision of services**
- [ ] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [ ] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [ ] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

State regulations Virginia Administrative Code § 12VAC 30-110-70 through 90 and federal regulations, Code of Federal Regulations 42 CFR Part 431, Subpart E requires a "Notice of Appeal Rights" be sent to individuals who have an adverse action related to choice of HCBS versus institutional services, choice of providers, and/or had a Medicaid-covered service denied, reduced, suspended, terminated or not acted upon within required time frames.

The individual must be notified in writing of the right to a hearing and the procedure for requesting a hearing at the time of the application and at the time of any adverse action by DMAS, the PA contractor, the screening team, or the DSS. For applicants and individuals not familiar with English, a translation of the appeal rights understood by the applicant or individual must be available. Appeal rights at the time of any action by DMAS, the service authorization contractor, the screening team, or DSS must be issued at least ten (10) days prior to the date of action, except for specified exceptions. The individual then has thirty (30) days from the date of denial to request an appeal.

When an individual's request for a Medicaid-covered service is denied, reduced, suspended, terminated, or not acted upon within required time frames, DMAS or the provider must send the written notification of the action and the right to appeal the action to the individual.

Unless otherwise specified, written notification must be mailed to the individual or legal guardian at least 10 days prior to the date of action when an agency reduces, suspends, or terminates one or all Medicaid-covered service(s).

When an applicant is denied initial enrollment into the waiver due to not meeting all criteria, the screening team sends a letter to the applicant notifying him or her of the determination and provides information on how to file an appeal with the Department of Medical Assistance Services.

When a request is submitted to the service authorization contractor that is denied or not fully approved as requested, including dates and units of service, a letter is generated from the Virginia Medicaid Management Information System (MMIS)to the individual stating the requested and approved amounts of service, the reason for the denial or reduction, and information on how to file an appeal with the Department of Medical Assistance Services.

If an individual is terminated from the waiver by DMAS, for reasons other than loss of Medicaid eligibility, a letter is sent to the individual notifying him or her of the action and providing information on how to file an appeal with the Department of Medical Assistance Services.

Fair hearing rights are applicable for FFS and Cardinal Care managed care 1915(b) participants. Individuals will receive a letter describing their right to continue receiving services while the appeal is under consideration. A copy of the notice of adverse action and the opportunity to request a fair hearing is kept in the participant's record.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

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

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).

Any suspected instances of abuse, neglect, or exploitation are required by Virginia law to be reported to the Virginia Department of Social Services. Reports can be made by using the 24 hour toll-free hotline or by contacting the Local Department of Social Services in which the individual resides.

The state defines abuse, exploitation, and neglect in the following manner:
Abuse" means the willful infliction of physical pain, injury or mental anguish or unreasonable confinement of an adult. This includes physical, verbal, and sexual abuse. Unreasonable confinement includes physical or chemical restraints, or isolation. Abuse includes wounds, scratches, bruises, burns, verbal assaults, threats, intimidation, broken bones, sprains, dislocations, restraints, seclusion, and sexual abuse.
Exploitation" means the illegal, unauthorized, improper, or fraudulent use of an adult or his/her funds, property, benefits, resources or other assets for another's profit, benefit or advantage, including a caregiver or person serving in a fiduciary capacity, or that deprives the adult of his/her rightful use of or access to such funds, property, benefits, resources, or other assets.
Neglect" means that an adult is living under such circumstances that he is not able to provide for himself or is not being provided services necessary to maintain his physical and mental health and that the failure to receive such necessary services impairs or threatens to impair his well-being.

Any person may voluntarily report suspected abuse, neglect, or exploitation (in various forms) to Adult Protective Services and Child Protective Services, including staff of financial institutions. Mandated reporters must report suspected abuse, neglect, and exploitation to Adult or Child Protective Services immediately. All providers of CCC Plus waiver services are identified as mandated reporters. In addition, The Code of Virginia identifies the following groups of persons as mandated reporters:

a) Any person licensed, certified, or registered by health regulatory boards listed in § 54.1-2503, except persons licensed by the Board of Veterinary Medicine:
* Board of Nursing: Registered Nurses (RN); Nurse Practitioners (NP); Licensed Practical Nurses (LPN); Clinical Nurse Specialists; Certified Massage Therapists;
Certified Nurse Aides (CNA)
* Board of Medicine: Doctors of Medicine, Surgery, Osteopathic Medicine, Podiatry, and Chiropractic; Interns and Residents; University Limited Licensees; Physician Assistants; Respiratory and Occupational Therapists; Radiological Technologists and Technologists Limited; Licensed Acupuncturists; Certified Athletic Trainers
* Board of Pharmacy: Pharmacists, Pharmacy Interns, and Technicians; Permitted Physicians; Medical Equipment Suppliers; Restricted Manufacturers; Humane Societies; Physicians Selling Drugs; Wholesale Distributors; Warehousers
* Board of Dentistry: Dentists and Dental Hygienists
* Board of Funeral Directors and Embalmers: Funeral Establishments, Services Providers, Directors, and Embalmers; Resident Trainees; Crematories; Surface Transportation and Removal Services; Courtesy Card Holders
* Board of Optometry: Optometrists
* Board of Nursing Home Administrators: Nursing Home Administrators
* Board of Counseling: Licensed Professional Counselors; Certified Substance Abuse Counselors; Counseling Assistants; Certified Rehabilitation Providers; Marriage and Family Therapists; Licensed Substance Abuse
Treatment Practitioners
* Board of Psychology: School, Clinical, and Applied Psychologist; Sex Offender Treatment Providers; School Psychologists Limited
* Board of Social Work: Registered Social Workers; Associate Social Workers; Licensed Social Workers; Licensed Clinical Social Workers
* Board of Audiology and Speech Pathology: Audiologists; Speech-Language Pathologists; School Speech-Language Pathologists
* Board of Physical Therapy: Physical Therapist and Physical Therapist Assistant.
* Any mental health services provider as defined in § 54.1-2400.1;
b) Any emergency medical services personnel certified by the Board of Health pursuant to § 32.1-111.5
c) Any guardian or conservator of an adult
d) Any person employed by or contracted with a public or private agency or facility and working with adults in an administrative, supportive, or direct care capacity
e) Any person providing full, intermittent or occasional care to an adult for compensation, including but not limited to companion, chore, homemaker and personal care workers
f) Any law-enforcement officer

The Virginia Department of Social Services receives and responds to all reports of critical incidents of abuse, neglect or exploitation. Reports are investigated by assigned DSS staff members who must initiate an investigation within 24 hours of report receipt.

DMAS monitors reports form the Virginia Department of Social Services of critical incidents reported to and investigated by the Department of Social Services.

Other critical events, such as medication errors or falls, are managed and monitored by the agency provider RN or SF. Deaths as a result of a medication error or fall due to suspected abuse or neglect is required to be reported to the medical examiner and law enforcement. Medication errors are reported to the Virginia Department of Health's Office of Licensure and Certification or the Department of Health Professions as appropriate.

Cardinal Care
In addition to the critical incident reporting requirements described above, each MCO has policies and procedures for reporting and management of critical incidents involving participants. These critical incidents include medication errors, severe injury or fall, theft, suspected physical or mental abuse or neglect, financial exploitation, and death of a participant. The policies and procedures that are reviewed and approved by DMAS shall reflect how the MCO identifies, documents, tracks, reviews, and analyzes critical incidents to identify and address potential and actual quality of care and/or health and safety issues.

The MCO shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations (including findings from Adult Protective Services (APS) and Child Protective Services (CPS) (if available); identify trends and patterns; identify opportunities for improvement; and develop, implement and evaluate strategies to reduce the occurrence of incidents.

The MCO shall require its staff and contracted providers to report, respond to, and document critical incidents to the MCO in accordance established requirements. The MCO's critical incident reporting process includes forms to be used to report critical incidents. The maximum timeframe for reporting an incident to the MCO is 24 hours with a follow-up written report within 48 hours.

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.

Information is provided by the screening team at initiation of CCC+ Waiver services. Individuals may make a report directly to Adult/Child Protective Services or the Department of Medical Assistance Services or other direct care providers or professionals to register a complaint on his or her behalf. Additionally, individuals receiving services through the consumer directed model receives information from the Services Facilitator regarding abuse, neglect and explotation and the information is incorporated in the Consumer-Directed Employer of Record manual. DMAS also provides a quarterly training to CD personal care attendants that includes information on reporting abuse, neglect, and exploitation.

Cardinal Care
In addition to the training and information described above, the MCO care coordinator provides education to participants on abuse, neglect, and 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.

The Virginia Department of Social Services receives and responds to all reports of critical incidents of abuse, neglect or exploitation. Reports are investigated by assigned DSS staff members who must initiate an investigation within 24 hours of report receipt. Investigations are finalized and closed as soon as possible given the nature and extent of the complaint. The complainant is informed of the investigation disposition (founded or unfounded) at case closure.

Unexplained deaths are considered critical incidents and are reported to DMAS by the MCO. DMAS ensures that these critical incidents are reported to the appropriate authorities for investigation which includes the state medical examiner, the appropriate licensing entity if applicable, or law enforcement when warranted.

Cardinal Care
The MCO shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations (including findings from Adult Protective Services (APS) and Child Protective Services (CPS) (if available); identify trends and patterns; identify opportunities for improvement; and develop, implement and evaluate strategies to reduce the occurrence of incidents.

The MCO shall require its staff and contracted providers to report, respond to, and document critical incidents to the MCO in accordance established requirements. The MCO's critical incident reporting process includes forms to be used to report critical incidents. The maximum timeframe for reporting an incident to the MCO is 24 hours with a follow-up written report within 48 hours.

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

The Department of Medical Assistance Services is responsible for monitoring the report of and response to critical incidents/events affecting waiver participants through a review of reports provided by the Department of Social Services as well as those provided by the MCO. DMAS receives reports regarding investigations of critical incidents and events from the Virginia Department of Social Services and the MCOs and is reviewed on a quarterly basis by the Quality Improvement Team. The data reports indicates the type of incident investigated and the disposition of the investigation, as well as waiver participant demographics. Recommendations by the Quality Improvement Team regarding incident trends or sentinel events will be made to the Integrated Care Division Director for action.

Unexplained deaths are considered critical incidents and are reported to DMAS by the MCO. DMAS ensures that these critical incidents are reported to the appropriate authorities for investigation which includes the state medical examiner, the appropriate licensing entity if applicable, or law enforcement when warranted.

Appendix G: Participant Safeguards

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

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

◉ **The state does not permit or prohibits the use of restraints**

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

Licensing entities monitor the prohibition of restraints of seclusion for agency-directed providers during scheduled licensing reviews. The Department of Medical Assistance Services monitors the use of restraints or seclusion by providers of consumer-directed services through CD Services Facilitators on a quarterly basis.

Licensing reviews are conducted periodically. The SF provides oversight routine and re-assessment visits. Agencies contracted with MCOs in Cardinal Care are licensed and undergo licensing reviews not less than biennially.

○ **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

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:

Licensing entities monitor the prohibition of restrictive interventions for agency-directed providers during scheduled licensing reviews. The Department of Medical Assistance Services monitors use of restrictive interventions by providers of consumer-directed services through CD Services Facilitators on a quarterly basis.

Additionally, MCOs monitor providers to ensure that participants are free from restrictive interventions.

Licensing reviews are conducted periodically. The SF provides oversight routine and re-assessment visits. Agencies contracted with MCOs in Cardinal Care are licensed and undergo licensing reviews not less than biennially.

○ **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

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:

Licensing entities monitor the prohibition of restrictive interventions for agency-directed providers during scheduled licensing reviews. he Department of Medical Assistance Services monitors use of restrictive interventions by providers of consumer-directed services through CD Services Facilitators on a quarterly basis.

Additionally, MCOs monitor providers to ensure that participants are free from restrictive interventions.

Licensing reviews are conducted periodically. Agencies contracted with MCOs in Cardinal Care are licensed and undergo licensing reviews not less than biennially.

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

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

- (●) **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ( ) **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

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

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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
HSW1. Number and percent of unexplained deaths (deaths resulting from other than natural causes) in which appropriate actions were taken n: number of unexplained deaths in appropriate actions were taken d: number of unexplained deaths.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
HSW2. Number and percent of participant's records with indications of abuse, neglect, exploitation or unexplained death documenting appropriate actions taken. N: Number of participant's records with indications of abuse, neglect, exploitation or unexplained death documenting appropriate actions taken D: Total number of participant's records with indications of abuse, neglect or exploitation.

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

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

		95% confidence level and 5% confidence interval
☒ **Other** Specify: MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

HSW3. Number and percent of participant with indications of safety concerns in which appropriate actions were taken. N: participant with indications of safety concerns in which appropriate actions were taken D: Total number of individual's records with indications of safety concerns.

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

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
HSW4. Number and percent of substantiated APS reports involving participants in which appropriate services were offered. N: # participants offered services as a result of a substantiated APS report D: # substantiated APS reports for participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
VDSS Databridge

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

Agency		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: VDSS	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
HSW5. Number and percent of participants for whom critical incidents were reported in which appropriate action was taken. N: Number of critical incidents with appropriate action taken D: Number of critical incidents reported

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
HSW6. Number and % of participant's records with indications of the use of restrictive interventions (restraints/seclusion) in which the appropriate licensing authorities were notified. N. # participant's records with indications of the use of restraints/seclusion in which the appropriate licensing entity was notified D. # participant's records with indications of the use of restraints/seclusion

Data Source (Select one):
Critical events and incident reports

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
HSW7. Number and percent of waiver participants 12 months–19 years of age who had a visit with a PCP. N: Number of participants 12 months - 19 years of age who had a visit with a PCP D: Number of participants 12 months - 19 years of age

Data Source (Select one):
Other
If 'Other' is selected, specify:
NCQA data

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

		Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
HSW8. Number and percent of participants receiving PDN who experience a critical

incident (including ventilator-associated pneumonia, central line infections, decubitus ulcers and uti) in which appropriate action was taken. N: Number receiving PDN who experience a critical incident in which appropriate action was taken D: Number receiving PDN who experienced a critical incident

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
HSW9. Number and percent of participants 20 years and older who had an ambulatory or preventive care visit during the year. N: Number of participants 20 years and older who had an ambulatory or preventive care visit D: Number of participants 20 years and older

Data Source (Select one):
Other
If 'Other' is selected, specify:
NCQA data

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Each MCO is required to have a critical incident reporting system. MCOs are required to report this information to DMAS on a continuous and on-going basis.

b. Methods for Remediation/Fixing Individual Problems

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

the methods used by the state to document these items.

DMAS QMR staff identifies problems with any of the above measures for a given provider, they each require a corrective action plan to be developed and implemented by the provider. Failure to do so jeopardizes the Medicaid provider agreement.

Individual providers with systemic problems will be targeted for technical assistance/training from DMAS. These events and their results will be documented in quarterly reports of technical assistance.

Should the DMAS Quality Improvement Team uncover Abuse, Neglect, or Exploitation during a Quality Management Review that has not been reported, DMAS staff are required to refer the incident to APS or CPS.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

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

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

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

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

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DMAS conducts quarterly Quality Improvement Team (QIT) meetings that includes quality compliance and monitoring staff from DMAS and the MCOs. The purpose of the QIT is to identify compliance issues and propose systemic improvements to meet quality expectations. Members of the QIT include DMAS quality management and waiver policy development staff as well as quality monitoring staff from each MCO.

MCOs will conduct QMRs and submit data on each performance measure to include compliance rates and any remediation efforts required. This information will be received by DMAS on an on-going basis. The reports from the MCOs along with FFS review data will be aggregated and reviewed on a quarterly basis for analysis and presented at the quarterly QIT meetings.

DMAS and MCO staff members determine provider compliance for each performance measure during the review process. A DMAS staff member is assigned to each performance measure and is tasked with aggregating reported data gathered from the reviews. The staff member performs trend analysis of their assigned measure and makes a report to the QIT along with recommendations on system improvements when the measure consistently falls below the threshold of 86% compliance.

Any performance measure with a compliance rate of 86% or less is discussed during the QIT meeting. The team reviews trends and any contributing factors that may have impacted the compliance rate. Systemic improvement plans are developed when compliance falls below the threshold for three consistent quarters.

Agencies and waiver providers receive immediate feedback at the conclusion of QMR visits. This information is released to participants, families, or other interested parties upon request.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Specific DMAS staff, members of QIT, are responsible for obtaining and analyzing data for each of the performance measures. When system design changes are made, these staff are responsible for analyzing the effectiveness of the change relative to their areas of responsibility, and reporting back to the QIT. As a whole, the QIT reviews the trends and effectiveness of the system changes and determines if further changes are indicated.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality strategy is evaluated annually, to ensure that the performance measures, data collection methods, and the quality strategy as a whole are effective and efficient in quantifying the success of meeting CMS assurances.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

DMAS requires all providers of services to comply with state and federal laws and regulations and holds them accountable for this. While DMAS does not impose an independent audit requirement for participating providers, provider agencies may be required to obtain an independent audit as a part of the licensing process through the Virginia Department of Health. Some provider agencies are exempt from licensing to be approved for payment by the DMAS per section 32.1-162.8 of the Code of Virginia. Providers exempt from licensing remain subject to complaint investigations in keeping with state law. The provider is responsible to provide DMAS all documentation that will verify services were rendered as billed. This would entail both medical and personnel records.

DMAS ensures financial integrity and accountability through multiple processes occurring across several divisions. The Fiscal and Purchases Division is responsible for the timely and accurate processing and recording of financial transactions to include collection of provider and recipient overpayments The Fiscal Division is charged with recovering overpayments and verifying proper documentation of the amounts. This division does not perform reviews.

The Internal Audit Division reviews claims for correct billing performing tests on claims in the MMIS for patterns that are anomalies across provider types. The Division focuses on the accurate processing of claims through MMIS to identify possible patterns of fraud, waste and/or abuse. This division uses concurrent auditing of claims to uncover any problems in the waiver, using over 300 checks on a continuous basis before claims are paid. They also review claims after they are paid to identify irregularities in payment patterns.

The Program Integrity Division (PID) conducts financial reviews utilizing internal staff as well as contractors acquired through a competitive procurement process. The Provider Review Unit (PRU), a sub-unit of the External Provider Audit and Policy (EPAP) Unit, and its audit contractors investigate allegations of provider aberrant billing practices and potential abuse that result in overpayments of Medicaid benefits. The PRU receives allegations from providers, state agencies, law enforcement agencies, individuals, and other DMAS units. These allegations typically involve misspent funds involving fee-for-service provider issues such as: billing for a service using a code that the provider has previously been instructed not to use, billing for more expensive services or procedures than were actually provided or performed (commonly known as up-coding), billing for services that were never rendered, performing medically unnecessary services, and misrepresenting non-covered treatments as medically necessary covered treatments.

The PRU conducts on-site and desk reviews of medical and personnel records to determine if services were provided as billed. These reviews also determine if the services were provided by qualified staff members. The PID utilizes fraud and abuse detection technology to data mine large amounts of information stored in data warehouses to identify patterns, associations, clusters, outliers, and other red flag phenomena that indicate the presence of possible fraud, waste, and abuse. The Fraud and Abuse Detection System (FADS), developed for DMAS by Optum, is a web-based product suite that employs data-mining of provider, member, and claims data to deliver actionable intelligence and provide investigative leads. FADS aids in preventing erroneous payments, researching inappropriate payments, confidently pursuing suspicious activity, compiling and accessing accurate information, determining which providers are exceeding the billing norms for their peer groups and increasing recoveries.

The supervisor of the PRU determines which cases will be reviewed by desk review and which cases will be an on-site audit. On-site audits may occur based upon FADS information in conjunction with referral information. Additionally, contractors propose a percentage of desk and on site reviews; DMAS approves this proposal prior to audits being conducted. DMAS does not seek to select a representative sample, as we seek to retract only on identified overpayments, not through extrapolation.

Using FADS data, management reports can be generated detailing the status of each review. Once providers are selected for review, the PRU supervisor requests a 12 months paid claims history for each provider. The claims history is analyzed to identify the sample of claims to be reviewed. The assigned analyst will request medical records for the sample selected. During this step of the review process, the analyst attempts to identify potential abusive billing practices. At any point in the review process, the services of the Medical Support Unit may be utilized when further clinical input is needed for medical issues.

After reviewing the records, the PRU Analyst completes the review and closes the case if there is no abuse (no billing errors are identified) and send them correspondence indicating such. When billing errors have been identified, a preliminary notification is sent to the provider for input into the preliminary audit findings. The provider is provided an opportunity to respond to the preliminary report as well as submit any additional documentation in support of their paid claims. The analyst will complete the review and an overpayment letter is sent to the provider and recovery is sought regardless of the dollar value. If the provider disagrees, they have the right to appeal.

The provider has four opportunities to provide input to the audit: Preliminary Findings, Request for an Informal Fact Finding Conference (IFFC), Formal Evidential Hearing, and Circuit Court. All are dictated by State regulations and handled by the Department's Appeals Division.

The PRU could potentially review any provider group. The unit monitors provider activity to identify potentially fraudulent or abusive billing practices; develop corrective action plans; recommend policy changes to prevent abusive billing practices when necessary; and to refer abusive or potentially fraudulent providers to other state agencies. Cases are referred to Medicaid Fraud Control Unit (MFCU) when alleged suspicion of fraud is suspected. The Sr. Policy Advisor serves as the liaison to the MFCU and is responsible for reviewing and submitting referrals to the MFCU. The MFCU determines if the case warrants further investigation as fraud.

DMAS undergoes an annual independent audit through the Virginia Auditor of Public Accounts, which includes a review of the waiver, to ensure compliance with state and federal accounting practices. The Virginia Auditor of Public Accounts is the entity responsible for conducting the periodic independent audit of the waiver program under the provisions of Single Audit Act. DMAS is also subject to audits from CMS through the medical integrity audits.

Cardinal Care
The MCO contractor plays a large role in the financial integrity and accountability of the waiver. The MCO provides the department with a copy of its annual audit report required by the Bureau of Insurance at the time it is submitted to the Bureau of Insurance. DMAS reserves the right to require the MCO to engage the services of an outside independent auditor to conduct a general audit of the contractor's major managed care functions performed on behalf of the Commonwealth. The contractor provides the department a copy of such an audit within 30 calendar days of completion of the audit.

The MCO is required to develop a written Program Integrity Plan that defines how the MCO contractor will identify and report suspected fraud, waste, and abuse by network providers and members. This plan is submitted to DMAS annually and must include a process to act as or sub-contract with a contractor for recovery audit purposes. The plan also identifies goals and objectives and describes the processes involved including data mining, software, and audit findings. The MCO submits a quarterly report to DMAS including all activities conducted and findings. The quarterly reports will be reviewed and checked to ensure accuracy. Once the accuracy of the report has been verified, the results from each of the MCOs will be combined into a single report for all participating MCOs and will be shared with all divisions to utilize in their oversight purposes. Particularly, as required under the new CMS Managed Care Regulation, identified/recovered overpayments will be utilized by our Provider Reimbursement Division to make adjustments to the rate-setting data used to set our capitated rates.

Additionally, the MCO is responsible for the credentialing of all providers in the network.
DMAS reviews and approves the MCO's Program Integrity Plan to ensure it meets or exceeds the standards used by DMAS for FFS. DMAS reviews on an on-going basis provider dashboards, claims, and utilization for each MCO.

DMAS Program Operations Division checks enrollment against the death file on a monthly basis to identify enrolled individuals for whom a death certificate has been issued. Capitation payments made to managed care organizations (MCOs) for coverage of these individuals in months after their death are retracted from the MCOs. In 2014, DMAS utilized a data analytics contractor to conduct an independent review of payments made on behalf of individuals after their date of death to verify that this process was working correctly. In addition, the DMAS Recipient Audit Unit conducts investigations of all Medicaid recipient groups to identify individuals who do not meet the qualifications for Medicaid enrollment. Individuals determined to be enrolled incorrectly are dis-enrolled and any improperly paid capitation payments are recovered from the Medicaid recipient.

The state will work with the MCO contractor to ensure fiscal integrity. This includes quarterly on-site reviews of the MCO program integrity processes and outcomes, a quarterly collaborative at which the MCOs, MFCU and DMAS discuss fraud, waste and abuse prevention and detection, and review and follow up of referrals made by the MCOs for cases of fraud or other PI issues.

If an issue is referred as "Suspected Provider Fraud", the cases are immediately forwarded on to our Medicaid Fraud Control Unit. In addition, our Provider Review Unit analyzes encounter and FFS claims to determine if that provider's claims data indicates similar FFS billing issues, the Provider Review Unit will schedule an audit of that provider's FFS claims. A summary of this claims analysis is provided to MFCU along with the referral

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
FA1. Number and percent of adjudicated waiver claims that were submitted using the correct rate as specified in the waiver application. N: Number of adjudicated claims submitted using the correct rate. D: Total number of adjudicated claims

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

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

☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
FA2. Number and percent of rates consistent with the approved rate methodology N: Number of rates consistent with the approved rate D: Number of rates

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Encounter data

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

If a problem is discovered, the assigned DMAS Quality Management Review Analyst will work with the specific DMAS contract monitor and/or the DMAS Information Management Division to identify the specific reasons for improper payments and implement corrective action.

If DMAS staff identifies problems with the above measure for MCOs, a corrective action plan is required to be developed and implemented by the MCO.

If claims have been paid inappropriately, referral is made to DMAS Program Integrity Division for collection of overpayment.

Individual providers with systemic problems will be targeted for technical assistance/training from DMAS. These events and their results will be documented in quarterly reports of technical assistance.

During a provider audit, a preliminary report is generated and given to the provider at which time they are allowed 30 days to provide additional documentation to mitigate any errors. The additional documentation is reviewed and thereafter a final overpayment report is generated. If the provider disagrees with the findings, they have the right to file an appeal.

The provider has four opportunities to provide input to the audit: Request for Reconsideration, Request for an Informal Fact Finding Conference (IFFC), Formal Evidential Hearing, and Circuit Court. All are dictated by State regulations and handled by the Department's Appeals Division.

DMAS does not perform on-site, unannounced visits for payment review.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

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

The Provider Reimbursement Division is responsible for rate determination and ensures that rates are based on the approved methodologies; are in accordance with authorized funding; and are consistent with economy, efficiency, and quality of care.
Rates are part of the state agency fee schedule and are reimbursed on a prospective, fee-for-service basis, with the exceptions discussed below. There is no differentiation between agency-directed (AD) and consumer-directed (CD) services rate determination. CD attendants working an average of 20 hours per week or at least 90 hours a month may earn paid sick leave.
Rates vary by region with higher rates paid for services in Northern Virginia to account for higher wage and other costs compared to the rest of the Commonwealth. In general, rates are adequate to attract a sufficient number of providers to furnish services to individuals. A complete listing of all current waiver services rates are maintained on the DMAS Web site http://dmas.virginia.gov/for-providers/long-term-care/waivers/ and is available to the public for review Individuals may call DMAS to request a written copy of the rate schedule.
Rates were initially established by considering the rates for similar services and the estimated cost of services. Rates are consistent with economy, efficiency and quality of care.

Rates are not increased automatically for inflation but may be increased if authorized by the state budget through the VA General Assembly. Rate increases are subject to funding in the budget. DMAS recommendations, as well as lobbying by providers, recipients and the public are part of the annual legislative budget process. The agency may examine rate adequacy and make recommendations for changes to ensure rates are adequate to attract a sufficient number of providers to furnish services. The agency will solicit public input by convening a stakeholder committee on potential rate changes. Similar services covered by different waivers are paid the same rate across all waivers.
Burns & Associates, Inc. (B&A) now known as Health Management, a national consultant experienced in developing provider reimbursement rates for home and community based services was engaged to establish independent rate models that are intended to reflect the costs that providers face in delivering a given service. From January 2014 through January 2015, B &A, conducted an in-depth rate methodology study of the services. This study involved surveying a wide variety of public and private waiver providers, examining Bureau of Labor Statistics (BLS) data regarding staff compensation, and other metrics.
DMAS employed the B&A independent rate study model framework (DD service rate process) to develop the benchmark rates for personal care, respite care, and private duty nursing for all waivers. For these services, DMAS determined the appropriate BLS labor categories for the direct care worker and applied the median wages based on the BLS Virginia wage survey data. Based on the direct care worker model wages, DMAS applied the appropriate benefit ratios using data from the B&A analysis. Productivity factors and other model inputs were examined and modified to reflect the services provided in the EDCD waiver. The rate models are posted on the DMAS website at http://www.dbhds.virginia.gov/library/developmental%20services/va%20dbhds%20ratemodels_final_rev1_2016_03-22.pdf and were accepted previously for the DD waivers. The percentage for the benchmark rate is calculated by dividing the proposed (current rate with increase) rate by the benchmark rate.
Following the initial development of an updated rate methodology for most services, public comment was solicited, received, compiled and appropriate changes made.
Specific assumptions are made for these various costs, including:

- *The wage of the direct support professional*
- *Benefits for the direct support professional*
- *The productivity of the direct support professional (to account for non-billable responsibilities)*
- *Other direct care costs, such as transportation and program supplies*
- *Agency overhead costs-Agency overhead costs are divided into administrative and program support. Administrative costs are those associated with the operation of an organization, but which are not program-specific. Employees that are typically considered administrative include general management, financial/accounting, and human resource staff. Expenses associated with these staff (e.g., their office space, utilities, etc.) are also considered administrative. Program support costs are expenses that are neither direct care nor administrative. Such activities are program-specific, but not on behalf of an individual member. Examples include staff responsible for training direct care workers, program development, supervision, and quality assurance. Expenses associated with these staff (e.g., their office space, utilities, etc.) are also considered program support. The rate models assume that 11 percent of the total rates support agency administrative costs.*

In addition to cost assumptions, the rate models include other programmatic assumptions such as staffing ratios. The rate model assumptions are used to construct the fee-for-services rates, but the individual assumptions are not prescriptive to service providers. For instance, providers are not required to pay the wages assumed in the rate models. Rather, providers have the flexibility within the total rate to design programs that meet members' needs, consistent with service requirements and members' individual support plans.

While there is no formal schedule for annual cost of living increases to the rates, the use of detailed and transparent rate models allows for periodic review and adjustment of the rates. For example, if the cost of employer-sponsored health insurance increases, the rate models could be adjusted to account for this particular cost.
Constructing the rate models included several activities, including varied opportunities for public comment:
• Policy goals that could be affected by the rates were identified. These goals included providing adequate funding for direct support professionals' wages, benefits, and training to reduce turnover and professionalize the workforce; and encouraging individualized and person-centered supports, consistent with the home and community based services rule.
• A rate-setting advisory group comprised of providers was convened several times during the rate-setting process to serve as a 'sounding board' to discuss project goals and materials.
• All providers were invited to complete a survey related to their service design and costs.
• Benchmark data was identified and researched, including the Bureau of Labor Statistics' cross-industry wage and benefit data as well as rates for comparable services in other waiver programs.
• Proposed rate models that outline the specific assumptions related to each category of costs were developed.
This rate methodology was used for nursing services, personal assistance services, and respite care services. Using the rate methodology developed by Burns and Associates, DMAS staff developed a rate model for Adult Day Health Care (ADHC) services. The model incorporated a provider survey, site visits, and current BLS data.
Rate models for private duty nursing, personal care, and respite care are posted to http://www.dmas.virginia.gov/Content_pgs/pr-rsetting.aspx. The adopted rates for nursing, personal care, respite care, and adult day health care services are being funded at 80% of the benchmark rate. The adopted rate for adult day health care is NOVA/ROS 65%/71% of the benchmark rate.
For Personal Emergency Response Services, which has low utilization and few providers, the cost-based rates were compared to the rates paid by other states in order to ensure reasonableness. PERS monthly monitoring rates were identified in 1915(c) waivers for persons with DD in all 22 other states that covered PERS for validation. This comparison found that the average rate falls within the third quintile of these other states. The list of states originated from the Waiver Description/Waiver Factsheet info on the CMS website. The estimated costs were taken from Appendix J.
Reimbursement for environmental modifications, and assistive technology is based on approved cost up to a $5,000 annual limit. Reimbursement for transition services is based on approved cost up to a $5,000 lifetime limit.
The reimbursement methodology for Services Facilitation (SF) has recently been developed and follows the same model and process as the DD waiver services. The methodology used the same benefits packages and overhead assumptions as in the previous models and the direct care worker wages came from the BLS data. Staff from DMAS and DBHDS reviewed the productivity and task hour assumptions in the model for reasonability. Rates for SF will not be adjusted. The methodology is available at:
http://www.dbhds.virginia.gov/library/developmental%20services/housing/dds_service%20facilitation%20and%20crisis%20suppo

Cardinal Care
DMAS contracts with the actuarial firm of Mercer to develop capitation rates for managed care. The rates are developed using historical fee-for-service (FFS) data taken from recent available experience on the population that is expected to enroll in the program. Rates are developed in an actuarially sound manner and reflect services which are provided under the State plan as well as waiver services that are summarized in this 1915 (c) waiver application. Capitated rates are set following the requirements of 42 CFR 438.6(c). The historical base data is adjusted to reflect any differences in plan benefits between the historical base period and the projection period as well as anticipated savings under the new program. Base data is also adjusted to include any payments that are not processed through the MMIS system. Adjusted base period data is projected forward to the projection period using assumed Medical Cost/Trend Inflation derived from historical experience during the base period. An administrative expense component is developed based on historical experience directly related to the provision of the stated services. The administrative expense component is projected forward and added to the projected claims data to arrive at an actuarially sound capitation rate.

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:*

Provider billings flow directly to the State's claims payment system, with the exception of those provider billings for consumer-directed services, which are paid through the fiscal employer agent (FEA). Work shift entries for personal care and respite attendants are submitted directly to the FEA by the waiver participant. The FEA directly submits payment to the attendant.

Cardinal Care
Participating MCO plans do not submit billings to the state; DMAS pays capitation payments to participating plans based on DMAS and CMS' determination of eligibility for the FAD and plan enrollment. Capitation payments are made through the same fiscal agent used for the rest of the Medicaid program. Individuals enrolled in the FAD are identified through their benefit package.

Provider billings to the participating plans are made in terms of the provider's contract with the plan.

Billings for services not included in the State's contract for managed care flow directly to the State's claims payment system.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

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

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

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

approved service plan; and, (c) the services were provided:

DMAS assures that, when claims are paid, the individual is Medicaid-eligible at the time the services were rendered and the services being billed are approved services in the plan of care for that individual. First, all services must be authorized by the contracted entity. Secondly, prior to payment, all claims are processed using automated edits that:

1) Check for a valid service authorization;
2) Verify there is no duplicate billing;
3) Verify that the provider submitting claims has a valid participation agreement with DMAS;
4) Check for any service limits; and
5) Verify individual eligibility.

DMAS' Medicaid Management Information System (MMIS) is an automated claims processing and review system. The MMIS system has built in controls (system edits) to ensure provider billings are in accordance with state and federal regulations prior to claims being approved for payment. Currently there are over 1,550 system edits in the Virginia MMIS, which rejects duplicate claims, and claims for services or service levels that are not authorized under Medicaid policy as example. As a part of claims processing, DMAS also utilizes two products that consists of regularly-updated system edits which prevent improper payments. These packages are Correct Coding Initiative edits which were developed by CMS and Claim Check, a commercial software product. Changes or updates to the MMIS system edits are submitted on an Information Service Request form and reviewed by a MMIS change committee. Upon approval by the committee the changes or updates are programmed. The MMIS is updated quarterly to include the CMS updates to the National Correct Coding Initiative (NCCI) edits. Other covered service and service limit system edits are continually updated as needed due to changes to Virginia Medicaid policies.

DMAS requires service authorization for all services in the plan of care. All services billed are checked to ensure that there is a valid service authorization prior to payment of the claim. Claims that do not have a valid service authorization are denied.

The Program Integrity and Medicaid Fraud Units may be requested to conduct additional review of providers if QMR uncovers egregious errors or suspect practices by the provider.

Pursuant to § 32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate pursuant to § 32.1-313 of the Code of Virginia. Repayment and interest will not apply pending appeal. The DMAS Fiscal Division coordinates the collection of any payments due to DMAS.

Capitation payments to participating plans are paid through an approved MMIS. Providers not included in the State's contract for managed care are paid through the same fiscal agent services used for the Medicaid FFS program.

Cardinal Care
MCOs are responsible for claims verification and must maintain records for at least three years. In addition, MCOs must certify encounter claims that are submitted to DMAS.

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

- ○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ◉ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

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

a. Consumer-directed payroll for personal care and respite services are paid through the Fiscal Employer Agent contractor. The waiver individual directly submits attendant work shift entries to the contractor, which processes the billing and makes payment directly to the care attendant. The claim information is captured in the contractor's database system to satisfy reporting requirements to CMS and are subject to all audit and accounting oversight measures.

The administrative activity is a per member per month fee and includes the contractor's direct and indirect costs. Direct costs include staffing, project supplies and materials, facilities, software, equipment, telecommunications, postage, printing, and subcontracts. Indirect costs include administrative staffing and services, general purpose equipment, facilities, telecommunications and general use office supplies.

DMAS employs contract monitoring staff within the Office of Community Living to provide ongoing oversight for the administration of the contract for fiscal management services. The vendor provides a bi-weekly payroll register documenting the individual payments associated with eligible waiver individuals for each service provided to the individual by qualified assistant(s) for the pay period. DMAS staff authorize each voucher for payment through DMAS's Fiscal and Purchases Division for generation of payment through the Virginia Department of Accounts. The payroll process is subject to random audit through the various oversight entities, including the auditor of public accounts (Virginia Department of Accounts) and the DMAS Division of Internal Audit.

In addition, DMAS staff provide quarterly reports to the Budget and Contract Management Division within DMAS to ensure that the vendor complies with the requirements of the contract, including fiscal accountability.

The contractor is required to retain all records for a period of 6 years after final payment is made under the contract. When an audit, litigation, or other action involving records is initiated prior to the end of said period, however, records will be maintained for a period of 6 years following resolution of such action or longer if such action is still ongoing. All records remain the property of DMAS.

Capitation payments to participating plans are paid through the MMIS. Individuals enrolled in a managed care participating plan have a unique benefit plan code associated with the enrollment which is used to identify them for capitation payments. Payment amounts are stored in tables in the MMIS and are linked to individuals for payment. Rates vary by enrollee age and geographic location.

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

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

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

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

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

Consumer-directed payroll for personal care and respite services are paid through the Fiscal Employer Agent contractor. The waiver individual directly submits attendant work shift entries to the contractor, which processes the billing and makes payment directly to the care attendant. The claim information is captured in the contractor's database system to satisfy reporting requirements to CMS and are subject to all audit and accounting oversight measures.

The administrative activity is a per member per month fee and includes the contractor's direct and indirect costs. Direct costs include staffing, project supplies and materials, facilities, software, equipment, telecommunications, postage, printing, and subcontracts. Indirect costs include administrative staffing and services, general purpose equipment, facilities, telecommunications and general use office supplies.

DMAS employs contract monitoring staff within the Office of Community Living to provide ongoing oversight for the administration of the contract for fiscal management services. The vendor provides a bi-weekly payroll register documenting the individual payments associated with eligible waiver individuals for each service provided to the individual by qualified assistant(s) for the pay period. DMAS staff authorize each voucher for payment through DMAS's Fiscal and Purchases Division for generation of payment through the Virginia Department of Accounts. The payroll process is subject to random audit through the various oversight entities, including the auditor of public accounts (Virginia Department of Accounts) and the DMAS Division of Internal Audit.

In addition, DMAS staff provide bi-annual reports to the Procurement and Contract Management Division of DMAS to ensure that the vendor complies with the requirements of the contract, including fiscal accountability.

Capitation payments to participating plans are paid through the MMIS. Payment amounts are stored in tables in the MMIS and are linked to individuals for payment. Rates vary by enrollee age and geographic location.

b. DMAS contracts with a Fiscal Management Services company to make payment for all consumer directed services, to include processing of work shift entries, IRS withholdings and reporting, calculation for eligibility and maintenance of accrual and usage of paid sick leave, and direct payment of care attendants. Oversight of the FMS operations are conducted by a contract monitor employed by the Medicaid agency.

DMAS employs contract monitoring staff within the Office of Community Living to provide ongoing oversight for the administration of the contract for fiscal management services. The FEA provides weekly estimated and reconciled payroll registers, documenting the individual payments associated with eligible waiver individuals for each service provided to the individual by qualified assistant(s) for the pay period. DMAS staff authorizes each voucher for payment through DMAS' Fiscal Division for generation of payment through the Virginia Department of Accounts. The payroll process is subject to random audit through the various oversight entities, including the auditor of public accounts (Virginia Department of Accounts) and the DMAS Division of Internal Audit.

In addition, the FMS provides the DMAS fiscal office with quarterly, tax accrual reconciliation reports, annual FICA refund voucher reports, and annual unclaimed property reports for checks that have not been cashed.

Cardinal Care
Providers not included in the state's contract for managed care are paid through the same fiscal agent services used for the rest of the Medicaid program.

☒ ***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.

FEE FOR SERVICE
Payments for most CCC+ waiver services are made through Virginia's approved Medicaid Management Information System (VaMMIS). However, a few CCC+ waiver services are not directly reimbursed through VaMMIS. Consumer-directed payroll for personal care, respite services and transition services are paid through the Fiscal Management Services contractor. The waiver participant directly submits attendant work shift entries to the FEA, which processes the billing and makes payment directly to the care attendant. The claim information is still captured in the VaMMlS system to satisfy reporting requirements to CMS and are subject to all audit and accounting oversight measures.

Cardinal Care
Capitation claims are automatically generated each month in the Virginia MMIS based on current recipient managed care enrollment data. These claims are then paid through the MMIS claims adjudication and payment process, which applies the appropriate edits and generates payment to the MCOs via the MMIS reimbursement process (check or EFT). All capitation payments are also reported to the health plans monthly via the HIPAA 820 electronic transaction for reconciliation purposes.
f. providers are paid by managed care entity
FFS providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Participating plans receive and retain 100% of the total computable expenditure claimed by DMAS.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

- ◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

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

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

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

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

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

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

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

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

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

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

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

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

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

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

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

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

iii. Contracts with MCOs, PIHPs or PAHPs.

○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

◉ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these***

plans are made.

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

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

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

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

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

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

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

Respite may be provided in a Children's Residential Facility. Respite is limited to 480 hours and is reimbursed at the rate consistent with agency directed respite services which covers the cost of providing the waiver service to the individual. Rates do not cover the costs of individual's room and board.

Appendix I: Financial Accountability

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

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

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

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

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

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Hospital, 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	26550.43	8228.00	34778.43	35670.00	6974.00	42644.00	7865.57
2	26652.59	8392.00	35044.59	36384.00	7114.00	43498.00	8453.41
3	26737.37	8560.00	35297.37	37112.00	7256.00	44368.00	9070.63
4	26841.47	8731.00	35572.47	37854.00	7401.00	45255.00	9682.53
5	26963.09	8906.00	35869.09	38611.00	7549.00	46160.00	10290.91

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

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

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Hospital	Nursing Facility
Year 1	50040	317	49723
Year 2	50645	317	50328
Year 3	51998	317	51681
Year 4	53351	317	53034
Year 5	54704	317	54387

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.*

The projected average length of stay on the waiver is based on the average length of stay reported on the CMS-372 for SFY 2019 with no expected changes.

Appendix J: Cost Neutrality Demonstration

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

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

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

Calculations and projections are based on historical expenditure trends and utilization patterns of clients in the CCC+ Waiver as reported in the CMS-372 for SFY2019 and similar figures compiled for SFY2020 and SFY2021. Adult day health care has had reduced utilization throughout the COVID-19 pandemic but is expected to return to past levels. Fee-for-service utilization for all services has had reduced utilization because of the maintenance of effort requirements keeping members enrolled, but that too is expected to return to previous levels after the end of the public health emergency.

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:*

Calculations and projections are based on historical expenditure trends and utilization patterns for acute care of clients in the CCC+ Waiver as reported in the CMS-372 for SFY2019, and similar figures were compiled for SFY2020 and SFY2021. There have been disruptions in costs per person, particularly in acute care, throughout the public health emergency. This has resulted into a lack of insight on temporary versus permanent trends in utilization and costs. The Factor D' increase of 2% is based on a reflected increase in nursing home inflation available at the time of this waiver's renewal. All costs per person are expected to be volatile with changing enrollment due to the continuation of care requirements from the public health emergency, changing utilization patterns, and changing costs of care for those services with expenditures based on costs rather than set rates. The state shall amend projections if the actual growth rate is discovered not to align with the projected rate.

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:*

Calculations and projections are based on historical expenditure trends and utilization patterns of clients in skilled nursing facilities as reported in the CMS-372 for SFY2019, and similar figures were compiled for SFY2020 and SFY2021. Growth is estimated at 2% per year for nursing facility inflation. There have been disruptions in costs per person, particularly in acute care, throughout the public health emergency. This has resulted into a lack of insight on temporary versus permanent trends in utilization and costs. The Factor G increase of 2% is based on a reflected increase in nursing home inflation available at the time of this waiver's renewal. All costs per person are expected to be volatile with changing enrollment due to the continuation of care requirements from the public health emergency, changing utilization patterns, and changing costs of care for those services with expenditures based on costs rather than set rates. The state shall amend projections if the actual growth rate is discovered not to align with the projected rate.

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:*

Calculations and projections are based on historical expenditure trends and utilization patterns of acute care services for clients in skilled nursing facilities as reported in the CMS-372 for SFY2019, and similar figures were compiled for SFY2020 and SFY2021. Growth in per person costs is estimated at 2% per year. There have been disruptions in costs per person, particularly in acute care, throughout the public health emergency. This has resulted into a lack of insight on temporary versus permanent trends in utilization and costs. The Factor G' increase of 2% is based on a reflected increase in nursing home inflation available at the time of this waiver's renewal. All costs per person are expected to be volatile with changing enrollment due to the continuation of care requirements from the public health emergency, changing utilization patterns, and changing costs of care for those services with expenditures based on costs rather than set rates. The state shall amend projections if the actual growth rate is discovered not to align with the projected rate.

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	
Adult Day Health Care	

Waiver Services	
Personal Assistance Services	
Respite Care Services	
Services Facilitation	
Assistive Technology	
Environmental Modifications	
Personal Emergency Response System (PERS)	
Private Duty Nursing	
Transition Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *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. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							**12337412.55**
Adult Day Health Care	☐	day	101	27.10	50.86	**139208.91**	
Adult Day Health Care Capitated	☒	day	1426	189.00	45.26	**12198203.64**	
Personal Assistance Services Total:							**1099509128.51**
Consumer Directed Personal Assistance	☐	hour	2548	569.70	14.92	**21657806.35**	
Personal Assistance - Agency Capitated	☒	hour	22211	1503.90	18.48	**617289711.19**	
Consumer Directed Personal Assistance Capitated	☒	hour	27051	2177.70	7.50	**441817220.25**	
Personal Assistance - Agency	☐	hour	3135	334.40	17.88	**18744390.72**	

GRAND TOTAL:	**1328583439.93**
Total: Services included in capitation:	1264659363.80
Total: Services not included in capitation:	63924076.12
Total Estimated Unduplicated Participants:	**50040**
Factor D (Divide total by number of participants):	**26550.43**
Services included in capitation:	25272.97
Services not included in capitation:	1277.46
Average Length of Stay on the Waiver:	306

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Services Total:							**165271975.71**
Consumer Directed Respite Services Capitated	☒	hour	20942	419.40	8.89	**78081534.97**	
Respite Services - Agency	☐	hour	1438	119.00	18.90	**3234205.80**	
Respite Services - Agency Capitated	☒	hour	17122	242.30	19.01	**78866038.01**	
Consumer Directed Respite Services	☐	hour	1813	187.80	14.95	**5090196.93**	
Services Facilitation Total:							**13928300.18**
Services Facilitation	☐	service	3014	7.50	70.24	**1587775.20**	
Services Facilitation Capitated	☒	service	22987	8.90	60.32	**12340524.98**	
Assistive Technology Total:							**143852.83**
Assistive Technology Capitated	☒	service	88	0.80	1985.58	**139784.83**	
Assistive Technology	☐	service	1	1.00	4068.00	**4068.00**	
Environmental Modifications Total:							**4093364.75**
Environmental Modifications	☐	service	820	2.10	42.98	**74011.56**	
Environmental Modifications Capitated	☒	service	1235	1.30	2503.49	**4019353.20**	
Personal Emergency Response System (PERS) Total:							**1722784.92**
PERS	☐	month	8	0.10	1722.22	**1377.78**	
PERS Capitated	☒	month	7335	8.20	28.62	**1721407.14**	
Private Duty Nursing Total:							**31574972.80**

GRAND TOTAL:	**1328583439.93**
Total: Services included in capitation:	1264659363.80
Total: Services not included in capitation:	63924076.12
Total Estimated Unduplicated Participants:	**50040**
Factor D (Divide total by number of participants):	**26550.43**
Services included in capitation:	25272.97
Services not included in capitation:	1277.46
Average Length of Stay on the Waiver:	306

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Private Duty Nursing Capitated	☒	15 mins	182	3920.00	25.49	18185585.60	
Private Duty Nursing	☐	15 mins	134	3920.00	25.49	13389387.20	
Transition Services Total:							1647.68
Transition Services Capitated	☒	service	0	0.00	0.01	0.00	
Transition Services	☐	service	2	1.00	823.84	1647.68	

GRAND TOTAL:	1328583439.93
Total: Services included in capitation:	1264659363.80
Total: Services not included in capitation:	63924076.12
Total Estimated Unduplicated Participants:	50040
Factor D (Divide total by number of participants):	26550.43
Services included in capitation:	25272.97
Services not included in capitation:	1277.46
Average Length of Stay on the Waiver:	306

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							12709375.48
Adult Day Health Care	☐	day	104	27.10	50.86	143343.82	
Adult Day Health Care Capitated	☒	day	1469	189.00	45.26	12566031.66	
Personal Assistance Services Total:							1132488868.46
Consumer Directed Personal Assistance	☐	hour	2624	569.70	14.92	22303800.58	

GRAND TOTAL:	1349820635.97
Total: Services included in capitation:	1296704850.89
Total: Services not included in capitation:	53115785.08
Total Estimated Unduplicated Participants:	50645
Factor D (Divide total by number of participants):	26652.59
Services included in capitation:	25603.81
Services not included in capitation:	1048.79
Average Length of Stay on the Waiver:	306

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Assistance - Agency Capitated	☒	hour	22877	1503.90	18.48	635799231.14	
Consumer Directed Personal Assistance Capitated	☒	hour	27863	2177.70	7.50	455079413.25	
Personal Assistance - Agency	☐	hour	3229	334.40	17.88	19306423.49	
Respite Care Services Total:							170229321.82
Consumer Directed Respite Services Capitated	☒	hour	21570	419.40	8.89	80423011.62	
Respite Services - Agency	☐	hour	1481	119.00	18.90	3330917.10	
Respite Services - Agency Capitated	☒	hour	17636	242.30	19.01	81233585.23	
Consumer Directed Respite Services	☐	hour	1867	187.80	14.95	5241807.87	
Services Facilitation Total:							14346137.30
Services Facilitation	☐	service	3104	7.50	70.24	1635187.20	
Services Facilitation Capitated	☒	service	23677	8.90	60.32	12710950.10	
Assistive Technology Total:							148618.22
Assistive Technology Capitated	☒	service	91	0.80	1985.58	144550.22	
Assistive Technology	☐	service	1	1.00	4068.00	4068.00	
Environmental Modifications Total:							4216039.07
Environmental Modifications	☐	service	845	2.10	42.98	76268.01	
Environmental Modifications Capitated	☒	service	1272	1.30	2503.49	4139771.06	

GRAND TOTAL:	**1349820635.97**
Total: Services included in capitation:	1296704850.89
Total: Services not included in capitation:	53115785.08
Total Estimated Unduplicated Participants:	**50645**
Factor D (Divide total by number of participants):	**26652.59**
Services included in capitation:	25603.81
Services not included in capitation:	1048.79
Average Length of Stay on the Waiver:	306

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System (PERS) Total:							**1774415.40**
PERS	☐	month	8	0.10	1722.22	**1377.78**	
PERS Capitated	☒	month	7555	8.20	28.62	**1773037.62**	
Private Duty Nursing Total:							**13906212.54**
Private Duty Nursing Capitated	☒	15 mins	249	1670.90	30.85	**12835268.98**	
Private Duty Nursing	☐	15 mins	284	302.40	12.47	**1070943.55**	
Transition Services Total:							**1647.68**
Transition Services Capitated	☒	service	0	0.00	0.01	**0.00**	
Transition Services	☐	service	2	1.00	823.84	**1647.68**	

GRAND TOTAL:	**1349820635.97**
Total: Services included in capitation:	1296704850.89
Total: Services not included in capitation:	53115785.08
Total Estimated Unduplicated Participants:	**50645**
Factor D (Divide total by number of participants):	**26652.59**
Services included in capitation:	25603.81
Services not included in capitation:	1048.79
Average Length of Stay on the Waiver:	306

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							**13089892.56**
Adult Day	☐					**147478.74**	

GRAND TOTAL:	**1390289962.68**
Total: Services included in capitation:	1335573434.01
Total: Services not included in capitation:	54716528.66
Total Estimated Unduplicated Participants:	**51998**
Factor D (Divide total by number of participants):	**26737.37**
Services included in capitation:	25685.09
Services not included in capitation:	1052.28
Average Length of Stay on the Waiver:	306

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Health Care		day	107	27.10	50.86		
Adult Day Health Care Capitated	☒	day	1513	189.00	45.26	**12942413.82**	
Personal Assistance Services Total:							**1166459872.83**
Consumer Directed Personal Assistance	☐	hour	2703	569.70	14.92	**22975294.57**	
Personal Assistance - Agency Capitated	☒	hour	23563	1503.90	18.48	**654864592.54**	
Consumer Directed Personal Assistance Capitated	☒	hour	28699	2177.70	7.50	**468733592.25**	
Personal Assistance - Agency	☐	hour	3326	334.40	17.88	**19886393.47**	
Respite Care Services Total:							**175334464.95**
Consumer Directed Respite Services Capitated	☒	hour	22217	419.40	8.89	**82835329.12**	
Respite Services - Agency	☐	hour	1525	119.00	18.90	**3429877.50**	
Respite Services - Agency Capitated	☒	hour	18165	242.30	19.01	**83670224.30**	
Consumer Directed Respite Services	☐	hour	1923	187.80	14.95	**5399034.03**	
Services Facilitation Total:							**14776291.78**
Services Facilitation	☐	service	3197	7.50	70.24	**1684179.60**	
Services Facilitation Capitated	☒	service	24387	8.90	60.32	**13092112.18**	
Assistive Technology Total:							**153383.62**
Assistive Technology Capitated	☒	service	94	0.80	1985.58	**149315.62**	

GRAND TOTAL:	**1390289962.68**
Total: Services included in capitation:	1335573434.01
Total: Services not included in capitation:	54716528.66
Total Estimated Unduplicated Participants:	**51998**
Factor D (Divide total by number of participants):	**26737.37**
Services included in capitation:	25685.09
Services not included in capitation:	1052.28
Average Length of Stay on the Waiver:	306

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology	☐	service	1	1.00	4068.00	**4068.00**	
Environmental Modifications Total:							**4341967.93**
Environmental Modifications	☐	service	870	2.10	42.98	**78524.46**	
Environmental Modifications Capitated	☒	service	1310	1.30	2503.49	**4263443.47**	
Personal Emergency Response System (PERS) Total:							**1827688.66**
PERS	☐	month	8	0.10	1722.22	**1377.78**	
PERS Capitated	☒	month	7782	8.20	28.62	**1826310.89**	
Private Duty Nursing Total:							**14304752.67**
Private Duty Nursing Capitated	☒	15 mins	256	1670.90	30.85	**13196099.84**	
Private Duty Nursing	☐	15 mins	294	302.40	12.47	**1108652.83**	
Transition Services Total:							**1647.68**
Transition Services Capitated	☒	service	0	0.00	0.01	**0.00**	
Transition Services	☐	service	2	1.00	823.84	**1647.68**	

GRAND TOTAL:	**1390289962.68**
Total: Services included in capitation:	1335573434.01
Total: Services not included in capitation:	54716528.66
Total Estimated Unduplicated Participants:	**51998**
Factor D (Divide total by number of participants):	**26737.37**
Services included in capitation:	25685.09
Services not included in capitation:	1052.28
Average Length of Stay on the Waiver:	306

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							**13478963.78**
Adult Day Health Care	☐	day	110	27.10	50.86	**151613.66**	
Adult Day Health Care Capitated	☒	day	1558	189.00	45.26	**13327350.12**	
Personal Assistance Services Total:							**1201457766.53**
Consumer Directed Personal Assistance	☐	hour	2784	569.70	14.92	**23663788.42**	
Personal Assistance - Agency Capitated	☒	hour	24270	1503.90	18.48	**674513587.44**	
Consumer Directed Personal Assistance Capitated	☒	hour	29560	2177.70	7.50	**482796090.00**	
Personal Assistance - Agency	☐	hour	3426	334.40	17.88	**20484300.67**	
Respite Care Services Total:							**180597988.78**
Consumer Directed Respite Services Capitated	☒	hour	22884	419.40	8.89	**85322215.94**	
Respite Services - Agency	☐	hour	1571	119.00	18.90	**3533336.10**	
Respite Services - Agency Capitated	☒	hour	18710	242.30	19.01	**86180561.33**	
Consumer Directed Respite Services	☐	hour	1981	187.80	14.95	**5561875.41**	
Services Facilitation Total:							**15219837.31**
Services Facilitation	☐	service	3293	7.50	70.24	**1734752.40**	
Services Facilitation Capitated	☒	service	25119	8.90	60.32	**13485084.91**	
Assistive Technology Total:							**158149.01**

GRAND TOTAL:	**1432019033.85**
Total: Services included in capitation:	1375658811.39
Total: Services not included in capitation:	56360222.47
Total Estimated Unduplicated Participants:	**53351**
Factor D (Divide total by number of participants):	**26841.47**
Services included in capitation:	25785.06
Services not included in capitation:	1056.40
Average Length of Stay on the Waiver:	306

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology Capitated	☒	service	97	0.80	1985.58	154081.01	
Assistive Technology	☐	service	1	1.00	4068.00	4068.00	
Environmental Modifications Total:							4471241.58
Environmental Modifications	☐	service	896	2.10	42.98	80871.17	
Environmental Modifications Capitated	☒	service	1349	1.30	2503.49	4390370.41	
Personal Emergency Response System (PERS) Total:							1882370.04
PERS	☐	month	8	0.10	1722.22	1377.78	
PERS Capitated	☒	month	8015	8.20	28.62	1880992.26	
Private Duty Nursing Total:							14751069.14
Private Duty Nursing Capitated	☒	15 mins	264	1670.90	30.85	13608477.96	
Private Duty Nursing	☐	15 mins	303	302.40	12.47	1142591.18	
Transition Services Total:							1647.68
Transition Services Capitated	☒	service	0	0.00	0.01	0.00	
Transition Services	☐	service	2	1.00	823.84	1647.68	

GRAND TOTAL:	**1432019033.85**
Total: Services included in capitation:	1375658811.39
Total: Services not included in capitation:	56360222.47
Total Estimated Unduplicated Participants:	**53351**
Factor D (Divide total by number of participants):	**26841.47**
Services included in capitation:	25785.06
Services not included in capitation:	1056.40
Average Length of Stay on the Waiver:	306

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							**13885143.28**
Adult Day Health Care	☐	day	113	27.10	50.86	**155748.58**	
Adult Day Health Care Capitated	☒	day	1605	189.00	45.26	**13729394.70**	
Personal Assistance Services Total:							**1237507382.23**
Consumer Directed Personal Assistance	☐	hour	2868	569.70	14.92	**24377782.03**	
Personal Assistance - Agency Capitated	☒	hour	24998	1503.90	18.48	**694746215.86**	
Consumer Directed Personal Assistance Capitated	☒	hour	30447	2177.70	7.50	**497283239.25**	
Personal Assistance - Agency	☐	hour	3529	334.40	17.88	**21100145.09**	
Respite Care Services Total:							**186014836.62**
Consumer Directed Respite Services Capitated	☒	hour	23571	419.40	8.89	**87883672.09**	
Respite Services - Agency	☐	hour	1618	119.00	18.90	**3639043.80**	
Respite Services - Agency Capitated	☒	hour	19271	242.30	19.01	**88764596.33**	
Consumer Directed Respite Services	☐	hour	2040	187.80	14.95	**5727524.40**	
Services Facilitation Total:							**15676773.90**
Services Facilitation	☐	service	3392	7.50	70.24	**1786905.60**	
Services Facilitation Capitated	☒	service	25873	8.90	60.32	**13889868.30**	
Assistive Technology Total:							**162914.40**

GRAND TOTAL:	**1474988637.95**
Total: Services included in capitation:	1416934557.32
Total: Services not included in capitation:	58054080.62
Total Estimated Unduplicated Participants:	**54704**
Factor D (Divide total by number of participants):	**26963.09**
Services included in capitation:	25901.85
Services not included in capitation:	1061.24
Average Length of Stay on the Waiver:	306

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology Capitated	☒	service	100	0.80	1985.58	158846.40	
Assistive Technology	☐	service	1	1.00	4068.00	4068.00	
Environmental Modifications Total:							4603860.03
Environmental Modifications	☐	service	923	2.10	42.98	83308.13	
Environmental Modifications Capitated	☒	service	1389	1.30	2503.49	4520551.89	
Personal Emergency Response System (PERS) Total:							1938694.20
PERS	☐	month	8	0.10	1722.22	1377.78	
PERS Capitated	☒	month	8255	8.20	28.62	1937316.42	
Private Duty Nursing Total:							15197385.62
Private Duty Nursing Capitated	☒	15 mins	272	1670.90	30.85	14020856.08	
Private Duty Nursing	☐	15 mins	312	302.40	12.47	1176529.54	
Transition Services Total:							1647.68
Transition Services Capitated	☒	service	0	0.00	0.01	0.00	
Transition Services	☐	service	2	1.00	823.84	1647.68	

GRAND TOTAL:	**1474988637.95**
Total: Services included in capitation:	1416934557.32
Total: Services not included in capitation:	58054080.62
Total Estimated Unduplicated Participants:	**54704**
Factor D (Divide total by number of participants):	**26963.09**
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Services not included in capitation:	1061.24
Average Length of Stay on the Waiver:	306