

STATE OF VERMONT

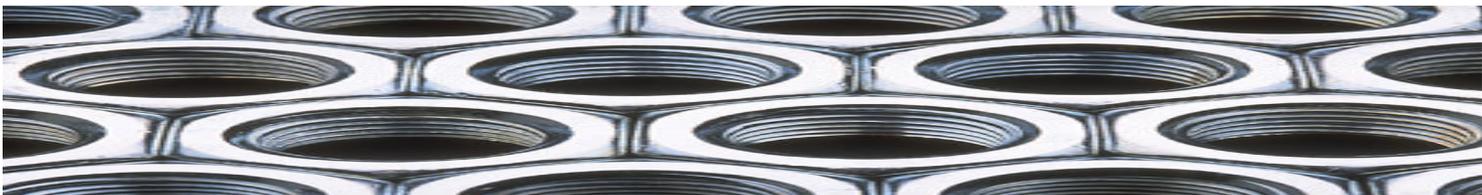
**Department of Developmental and Mental Health
Services**

Division of Developmental Services

RENEWAL APPLICATION FOR Waiver No. 0047.90R3

July 1, 2003 – June 30, 2008

**103 South Main Street
Waterbury, VT 05671-1601**



STATE OF VERMONT
SECTION 1915(C) WAIVER RENEWAL APPLICATION
MR/DD WAIVER NUMBER 0047.90.R3

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- a. Waiver services are limited to the following age groups (specify):
- b. Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):
- c. Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.
- d. Other criteria (specify):
- e. **Not applicable.**

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

- a. **Yes**
- b. **No**

7. A waiver of 1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

- a. **Yes**
- b. **No**
- c. **N/A**

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

- a. **Yes**
- b. **No (this will be calculated in the aggregate, not on an individual basis)**

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

- a. **Yes**
- b. **No**

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

a. **Case management**

b. Homemaker

c. Home health aide services

d. Personal care services

e. **Respite care**

f. Adult day health

g. **Habilitation**

Residential habilitation

Day habilitation

Prevocational services

Supported employment services

Educational services

h. Environmental accessibility adaptations

i. Skilled nursing

j. Transportation

k. Specialized medical equipment and supplies

l. Chore services

m. Personal Emergency Response Systems

n. Companion services

o. Private duty nursing

p. Family training

q. Attendant care

r. Adult Residential Care

Adult foster care

Assisted living

s. Extended State plan services (Check all that apply):

Physician services

Home health care services

Physical therapy services

Occupational therapy services

Speech, hearing and language services

Prescribed drugs

Other (specify):

t. **Other services (specify):**

Clinical Interventions

Crisis Services

u. The following services will be provided to individuals with chronic mental illness:

Day treatment/Partial hospitalization

Psychosocial rehabilitation

Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other

services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care, except in emergency situations. FFP will not be claimed for waiver services which are not included in the individual written plan of care.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.
15. FFP will not be claimed for the cost of room and board, with the following exception(s) (check all that apply): **N/A**
 - a. ___ When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).
 - b. ___ Meals furnished as part of a program of adult day health services.
 - c. ___ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means any meals, or other nutritional regimen.

16. The Medicaid agency provides the following assurances to CMS:
 - a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:
 1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);
 2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and,
 3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
 - b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and

control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

18. An effective renewal date of **July 1, 2003** is requested.
19. The State contact person for this request is **Theresa A. M. Wood**, who can be reached by telephone at **(802) 241-2614, or twood@ddmhs.state.vt.us**.
20. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: _____
Print Name: **Theresa A. M. Wood**
Title: **Director, Division of Developmental Services**
Date: **April 22, 2003**

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. The time required to complete this information collection is estimated to average 160 hours for each new and renewed waiver request and an average of 30 hours for each amendment, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, MD 21207 and to the Office of Information and Regulatory Affairs, OMB, Washington, D.C. 20503.

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

The waiver will be operated by _____, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

The waiver will be operated by the Department of Developmental and Mental Health Services, a separate division within the Single State agency. The Department of Developmental and Mental Health Services acts as the Medical Assistance Unit for services provided to people with developmental disabilities.

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITIONS OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

For all services, providers may be members of the individual’s family, with the following exceptions. Payment will not be made for services furnished to any person by the individual’s parent, step-parent or adoptive parent, or by the individual’s spouse, civil union partner, domestic partner or legal guardian. Family members who provide services must meet the same standards as providers who are unrelated to the individual (see provider qualifications). *The state will continue to pay for personal care assistance for up to thirty (30) days/hospitalization for waiver recipients (amended 06.06.04; effective 07.01.03).*

a. X Case Management

— Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1. X Yes 2. ___No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1. X Yes 2. ___No

X Other Service Definition (specify):

Service planning and coordination (case management) assists individuals and their families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of needed services and supports for a specific individual. Services and supports that are planned and coordinated may be formal (provided by the human services system) or informal (available through the strengths and resources of the family or community). Services and supports include discharge planning, advocacy and monitoring the well-being of individuals (and their

families), and supporting them to make and assess their own decisions.

b. X Respite care:

Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

X Other service definition (specify):

Respite assists family members, significant others (e.g., roommates, friends, partners), home providers and foster families to help support specific individuals with disabilities. Services are provided on a short-term basis because of the absence or need for relief of those persons normally providing the care to individuals who cannot be left unsupervised.

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. However, the State will not provide respite in a facility. Respite care will be provided in the following location(s) (check all that apply):

- Individual's home or place of residence or private home of a respite provider**
- Foster home**
- Medicaid certified Hospital
- Medicaid certified NF
- Medicaid certified ICF/MR
- Group home
- Licensed respite care facility
- Other community care residential facility approved by the State that is not a private residence (specify type):
- Other service definition (specify):

c. X Habilitation:

Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

X Other service definition (specify):

X Housing and home supports (residential habilitation) provide services, supports and supervision to individuals in and around their residences up to twenty-four (24) hours a day. This is the service or array of services

determined and documented through an individual planning process, including a services coordinator, to help an individual with developmental disabilities and his/her family, if applicable, to avoid institutional level of care for the person. It includes the provision of assistance and resources to individuals with developmental disabilities and their families in order to improve and maintain the individual's opportunities and experiences to be as independent as possible in their communities. Services include support to individuals in the acquisition and retention of skills related to everyday living. Resources (total of all goods purchased under all applicable services) provided are limited to a maximum of 25% of an individual's waiver budget or \$3,000, whichever is less, and must be related to the individual's support plan and funded areas of support. Exceptions to the dollar limit may be made for accessible transportation or home modifications required for accessibility due to a physical disability. Environmental modifications, adaptive equipment, transportation, etc., may be provided as component parts of housing and home supports and are included in the rate paid to providers.

Housing and home supports may be provided in the following settings:

1. Supervised/Assisted Living is regularly scheduled or intermittent supports provided to an individual who lives in his or her home or that of a family member.
2. Staffed living is residential living arrangements for one or two people, staffed full-time by providers.
3. Group living arrangements are for three or more people, staffed full-time by providers.
4. Foster families are individualized shared living arrangements for children and adults, offered within a home provider/foster family's home. Home providers/foster families are contracted workers and are not considered staff in their role as contracted providers.

X **Community supports (day habilitation)** are specific, individualized and goal oriented services that assist individuals (and families) in developing skills and social supports necessary to promote positive growth. These supports may include assistance in daily living, supportive counseling, support to participate in community activities, collateral contacts, and building and sustaining healthy personal, family and community relationships. Resources (total of all goods purchased under all applicable services) provided are limited to a maximum of 25% of an individual's waiver budget or \$3,000, whichever is less, and must be related to the

individual's support plan and funded areas of support.

Necessary assessments and therapies such as physical, occupation, speech, etc., are provided as component parts of community supports and are included in the rate paid to providers. Transportation is also a component part of community supports and is included in the rate paid to providers.

X **Work Supports (supported employment services)** assist transition age youth and adults in establishing and achieving career and work goals. Resources (total of all goods purchased under all applicable services) provided are limited to a maximum of 25% of an individual's waiver budget or \$3,000, whichever is less, and must be related to the individual's support plan and funded areas of support. Supported employment services include:

1. Employment assessment which involves evaluation of the individual's work skills, identification of the individual's preferences and interests, and the development of personal work goals.
2. Employer and job development that assists an individual to access employment and establish employer development and support. Activities for employer development include identification, creation or enhancement of job opportunities, education, consulting, and assisting co-workers and managers in supporting and interacting with individuals.
3. Job training that assists an individual to begin work, learn the job, and gain social inclusion at work.
4. Ongoing support to maintain employment that involves activities needed to sustain paid work by the individual. These supports and services may be given both on and off the job site, and may involve long-term and/or intermittent follow-up.

Therapies, environmental modifications, adaptive equipment, transportation, etc., are component parts of supported employment services and are included in the rate paid to providers. Payment will not be provided for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available

under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

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

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

d. X Clinical interventions

Clinical interventions are assessment, therapeutic, medication or medical services provided by clinical or medical staff, including a qualified clinician, therapist, psychiatrist or nurse. Clinical interventions include assessment, individual therapy, family therapy, group therapy, and medication and medical support and consultation.

e. X Crisis services

Crisis Services are time-limited, intensive, supports provided for individuals and families who are currently experiencing, or may be expected to experience, a psychological, behavioral, or emotional crisis. Services may also be provided to the individual's or family's immediate support system. These services are available 24 hours a day, 7 days a week.

APPENDIX B-2: PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
All waiver services	Community developmental services agencies	N/A	N/A	<p>All services are provided by or through Vermont’s designated agencies, other specialized service agencies or the Department itself pursuant to 18 VSA, Chapter 207, Sections 8901-8913.</p> <p>All services are monitored and/or supervised by a federal or State defined QDDP. People providing services are either directly employed by community agencies or by consumers, their families, or shared living providers. Supports must be provided by individuals at least eighteen (18) years of age who have a high school diploma or equivalent (G.E.D. or life experience) with training specific to the needs of the individual. For home supports, the provider must be twenty-one (21) years of age if the individual lives in the home of the provider. Relatives other than the parent, step-parent, adoptive parent, spouse, civil union partner, domestic partner or legal guardian may provide services.</p>

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

**APPENDIX B-3:
KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES**

A. KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

B. APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency. All residential programs serving three (3) or more unrelated individuals are required by the State of Vermont to be licensed by the Department of Aging and Disabilities, Division of Licensing and Protection.

APPENDIX C – ELIGIBILITY AND POST-ELIGIBILITY

APPENDIX C-1: ELIGIBILITY

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

- 1. **Low income families with children as described in section 1931 of the Social Security Act.**
- 2. **SSI recipients (SSI Criteria States and 1634 States).**
- 3. Aged, blind or disabled in 209(b) States who are eligible under § 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).
- 4. **Optional State supplement recipients.**
- 5. Optional categorically needy aged and disabled who have income at (Check one):
 - a. 100% of the Federal poverty level (FPL)
 - b. % Percent of FPL that is lower than 100%.
- 6. **The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).**

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

a. Yes b. No

Check one:

- a. The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or,
- b. **Only the following groups of individuals who would be eligible for**

Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver (check all that apply):

- (1) **A special income level equal to:**
 - 300% of the SSI Federal benefit (FBR)**
____% of FBR, which is lower than 300% (42 CFR 435.236)
\$____ which is lower than 300%
- (2) ____ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)
- (3) ____ Medically needy without spend down in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435.324.)
- (4) ____ Medically needy without spend down in 209(b) States. (42 CFR 435.330)
- (5) ____ Aged and disabled who have income at:
 - a. ____ 100% of the FPL
 - b. ____% which is lower than 100%.
- (6) ____ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7. Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8. ____ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

APPENDIX C-2: POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1. X **SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients' income.**

A. § 435.726--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual (check one):

A. X **The following standard included under the State plan (check one):**

(1) ___ SSI

(2) ___ Medically needy

(3) ___ The special income

level for the institutionalized

(4) ___ The following percent of the Federal poverty level): ___%

(5) X **Other (specify): 300% of SSI**

B. ___ The following dollar amount: \$ ___*

* If this amount changes, this item will be revised.

C. ___ The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A. ___ SSI standard

B. ___ Optional State supplement standard

C. ___ Medically needy income standard

D. ___ The following dollar amount: \$ ___*

* If this amount changes, this item will be revised.

E. ___ The following percentage of the following standard that is not greater than the standards above: _____% of standard.

F. ___ The amount is determined using the following formula:

G. X **Not applicable (N/A)**

3. Family (check one):

A. AFDC need standard

B. Medically needy income standard

The amount specified below 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 income standard established under 435.811 for a family of the same size.

C. The following dollar amount: \$ _____*

*If this amount changes, this item will be revised.

D. The following percentage of the following standard that is not greater than the standards above: % _____ of standard.

E. The amount is determined using the following formula:

F. Other

G. **Not applicable (N/A)**

b. Medical and remedial care expenses specified in 42 CFR 435.726.

**POST ELIGIBILITY
SPOUSAL POST ELIGIBILITY**

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

(A) Allowance for personal needs of the individual (check one):

- (a) ___ SSI Standard
- (b) ___ Medically Needy Standard
- (c) ___ The special income level for the institutionalized
- (d) ___ The following percent of the Federal poverty level: ___%
- (e) ___ The following dollar amount \$ ___**

**If this amount changes, this item will be revised.

(f) ___ The following formula is used to determine the needs allowance:

(g) X **Other (specify): 300% of SSI**

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1: INITIAL LEVEL OF CARE

A. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

B. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (check all that apply):

- Discharge planning team
- Physician (M.D. or D.O.)
- Registered Nurse, licensed in the State
- Licensed Social Worker
- Qualified Mental Retardation (Developmental Disabilities) Professional, as defined in 42 CFR 483.430(a) or by the State**
- Other (specify):

APPENDIX D-2: REEVALUATION OF LEVEL OF CARE

A. FREQUENCY OF REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (specify):

- Every 3 months
- Every 6 months
- Every 12 months**
- Other (Specify):

B. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (specify):

- Physician (M.D. or D.O.)
- Registered Nurse, licensed in the State
- Licensed Social Worker
- Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)
- Other (specify):

C. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (check all that apply):

- "Tickler" file
- Edits in computer system
- Component part of case management**
- Other (specify): Verification by the State on monthly Medicaid Waiver spreadsheet submissions**

APPENDIX D-3: RECORDS

A. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (check all that apply):
 - By the Medicaid agency in its central office
 - By the Medicaid agency in district/local offices
 - By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program**
 - By the case managers
 - By the persons or agencies designated as responsible for the performance of evaluations and reevaluations
 - By service providers**
 - Other (Specify):
2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

B. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is on file at the State.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

- The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.**
- The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

APPENDIX D-4: FREEDOM OF CHOICE

A. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:
 - a. informed of any feasible alternatives under the waiver; and,
 - b. given the choice of either feasible institutional or home and community-based services.
2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.
3. The following are attached to this Appendix:
 - a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing (**see attached Eligibility Form**);
 - b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;

This is accomplished at the time of the initial eligibility determination for home and community-based Medicaid waiver services. The individual recipient and/or their guardian indicate their choice by signing the original eligibility form. Also, the individual and/or their legal guardian is required to indicate their approval of the annual Individual Support Agreement, thereby indicating their choice for continuation of home and community-based waiver services.

- c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services. **See b. above.**

- d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

See attached “How to File an Appeal” brochure. The State also produced a video to inform individuals of their right to file an appeal. The State also requires that a letter indicating the individual’s right to a fair hearing under 42 CFR Part 431, Subpart E be sent to the individual and/or their legal guardian.

B. FREEDOM OF CHOICE DOCUMENTATION

Documentation of freedom of choice is maintained at the State and provider offices.

APPENDIX E - PLAN OF CARE

APPENDIX E-1: PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:
 - Registered nurse, licensed to practice in the State
 - Licensed practical or vocational nurse, acting within the scope of practice under State law
 - Physician (M.D. or D.O.) licensed to practice in the State
 - Social Worker (qualifications attached to this Appendix)
 - Case Manager**
 - Other (specify): individual recipient; see attached Individual Support Agreement Guidelines**

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.
 - At the Medicaid agency central office
 - At the Medicaid agency county/regional offices
 - By case managers**
 - By the agency specified in Appendix A
 - By consumers
 - Other (specify)

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:
 - Every 3 months
 - Every 6 months
 - Every 12 months**
 - Other (specify):

APPENDIX E-2: MEDICAID AGENCY APPROVAL

A. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

The initial plan of care is reviewed by the State with the waiver eligibility package or on site at the provider office.

Annually, a sample of individual plans of care are reviewed by the State's quality assurance teams to determine their appropriateness and the extent to which services are provided in accordance with the plan and quality practices.

B. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix. **See attached Individual Support Agreement Guidelines.**

APPENDIX F - AUDIT TRAIL

A. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.
2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.
3. Method of payments (check one):

Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

Other (describe in detail):

B. BILLING AND PROCESS AND RECORDS RETENTION

1. Outlined below is a description of the billing process. The State assures that all claims for payment of waiver services 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 approved plan of care;
 - c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the

Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

Yes.

No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

All claims are processed through an approved MMIS.

MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

C. PAYMENT ARRANGEMENTS

1. Check all that apply:

The Medicaid agency will make payments directly to providers of waiver services.

The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1: COMPOSITE OVERVIEW COST NEUTRALITY FORMULA

LEVEL OF CARE: ICF/MR

Renewal Year	Factor D	Factor D'	Factor G	Factor G'
Year 1 (07/01/03-06/30/04)	\$44,758	\$9,665	\$179,279	\$9,665
Year 2 (07/01/04-06/30/05)	\$47,264	\$10,206	\$189,319	\$10,206
Year 3 (07/01/05-06/30/06)	\$49,911	\$10,778	\$199,920	\$10,778
Year 4 (07/01/06-06/30/07)	\$52,706	\$11,381	\$211,116	\$11,381
Year 5 (07/01/07-06/30/08)	\$55,658	\$12,019	\$222,939	\$12,019

The average annual cost for Factor D and D' are based on the initial 372 report for the period 07/01/01 -- 06/30/02, with an inflation factor of 5.6% per year, which is equal to the Consumer Price Index for Medical Services for the period December 2001 – December 2002.

The average annual cost for Factor G is based on the actual costs for ICF/MR expenditures for the year ended 06/30/02, with an inflation factor of 5.6% per year as noted above. The average annual cost for Factor G' is equal to the average annual cost for Factor D'. The State has no reason to believe that institutional service recipients' costs will exceed home and community-based services waiver recipients' for related medical expenses.

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

Renewal Year	Factor C
Year 1 (07/01/03-06/30/04)	2,100
Year 2 (07/01/04-06/30/05)	2,250
Year 3 (07/01/05-06/30/06)	2,400
Year 4 (07/01/06-06/30/07)	2,550
Year 5 (07/01/07-06/30/08)	2,700

EXPLANATION OF FACTOR C

Check one:

The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year, within the funds appropriated by the State legislature each year.

The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform HCFA in writing of any limit that is less than factor C for that waiver year.

APPENDIX G-2: METHODOLOGY FOR DERIVATION OF FORMULA VALUES

**FACTOR D – AVERAGE ANNUAL COST PER INDIVIDUAL
LEVEL OF CARE: ICF/MR
UNIT: 1 Day**

Service	Description	Year 1	Year 2	Year 3	Year 4	Year 5
Service Planning & Coordination (Case Mgmt.)	# Undup. Ind.	2,100	2,250	2,400	2,550	2,700
	Avg. Annual Units	15	15	15	15	15
	Avg. Unit Cost	\$374	\$395	\$417	\$440	\$465
	Total Cost	\$11,781,000	\$13,329,360	\$15,014,191	\$16,845,922	\$18,835,723
Respite Care	# Undup. Ind.	1,638	1,755	1,872	1,989	2,106
	Avg. Annual Units	54	54	54	54	54
	Avg. Unit Cost	\$100	\$106	\$112	\$118	\$124
	Total Cost	\$8,845,200	\$10,007,712	\$11,272,687	\$12,647,955	\$14,141,901
Housing & Home Supports (Residential Hab.)	# Undup. Ind.	1,281	1,373	1,464	1,556	1,647
	Avg. Annual Units	365	365	365	365	365
	Avg. Unit Cost	\$85.67	\$90.47	\$95.53	\$100.88	\$106.53
	Total Cost	\$40,056,294	\$45,320,835	\$51,049,389	\$57,277,414	\$64,042,887
Community Supports (Day Hab.)	# Undup. Ind.	1,281	1,373	1,464	1,556	1,647
	Avg. Annual Units	260	260	260	260	260
	Avg. Unit Cost	\$66.17	\$69.88	\$73.79	\$77.92	\$82.28
	Total Cost	\$22,038,580	\$24,935,079	\$28,086,873	\$31,513,472	\$35,235,769
Work Supports (Supported Employ.)	# Undup. Ind.	483	518	552	587	621
	Avg. Annual Units	208	208	208	208	208
	Avg. Unit Cost	\$66.17	\$69.88	\$73.79	\$77.92	\$82.28
	Total Cost	\$6,647,703	\$7,521,401	\$8,472,106	\$9,505,703	\$10,628,494
Clinical Interventions	# Undup. Ind.	1,113	1,193	1,272	1,352	1,431
	Avg. Annual Units	17	17	17	17	17
	Avg. Unit Cost	\$125	\$132	\$139	\$147	\$155
	Total Cost	\$2,365,125	\$2,675,970	\$3,014,213	\$3,381,947	\$3,781,414
Crisis Services	# Undup. Ind.	2,100	2,250	2,400	2,550	2,700
	Avg. Annual Units	3	3	3	3	3
	Avg. Unit Cost	\$358.40	\$378.47	\$399.66	\$422.05	\$445.68
	Total Cost	\$2,257,920	\$2,554,675	\$2,877,586	\$3,228,652	\$3,610,012
	GRAND TOTALS	\$93,991,822	\$106,345,032	\$119,787,045	\$134,401,064	\$150,276,201
	Individuals	2,100	2,250	2,400	2,550	2,700
	Cost/Individual	\$44,758	\$47,264	\$49,911	\$52,706	\$55,658

Average length of stay = 348 days or 95.2% (average length of stay derived from initial 372 report for the period 07/01/01 – 06/30/02).

APPENDIX G-3: METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

- A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual (i.e., foster homes, group living, supervised/assisted living arrangements, or staffed living) (specify):

Housing and home supports (residential habilitation); however, housing and home supports may be provided in the home of the individual recipient. For example, supervised/assisted living is regularly scheduled or intermittent supports provided to an individual who lives in his or her home or that of a family member.

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

The State will not provide respite care in a facility.

- B. The following service(s) are furnished in the home of a paid caregiver (specify):

Housing and home supports (residential habilitation). See A. above.

Below is an explanation of the method used by the State to exclude Medicaid payment for room and board.

The State instructs providers to submit individualized budgets that exclude room and board payments. SSI and other client contributions (e.g., from wages, etc.) are the primary funding sources for room and board. Any room and board in excess of SSI resources or other individual income is paid with State general funds. The State sets the room and board amount, at least annually, by type of residential setting.

APPENDIX G-4: METHODS USED TO MAKE PAYMENT FOR HOUSING EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

The State will not reimburse separately for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

The State will reimburse for the additional costs of food and housing attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver.

APPENDIX G-5: FACTOR D'

LEVEL OF CARE: ICF/MR

Factor D' is computed as follows (check one):

Based on HCFA Form 2082 (relevant pages attached).

Based on initial HCFA Form 372 for the period 07/01/01 -- 06/30/02, with an inflation factor of 5.6% per year, which is equal to the Consumer Price Index for Medical Services for the period December 2001 – December 2002. See also Appendix G-1 for actual dollar amounts.

Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

Other (specify):

APPENDIX G-6: FACTOR G

LEVEL OF CARE: ICF/MR

Factor G is computed as follows:

- Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.
- Based on initial HCFA Form 372 for the period 07/01/01 -- 06/30/02, with an inflation factor of 5.6% per year, which is equal to the Consumer Price Index for Medical Services for the period December 2001 – December 2002; adjusted downward to reflect actual expenditures for the State’s only 6-bed ICF/MR. See also Appendix G-1 for actual dollar amounts.**
- Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.
- Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.
- Other (specify):

APPENDIX G-7: FACTOR G'

LEVEL OF CARE: ICF/MR

Factor G' is computed as follows (check one):

- Based on HCFA Form 2082 (relevant pages attached).
- Based on HCFA Form 372 for years ____ of waiver # ____, which serves a similar target population.
- Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.
- Other (specify): The average annual cost for Factor G' is equal to the average annual cost for Factor D' (based on the initial 372 report for the period 07/01/01 – 06/30/02 adjusted for inflation). The State has no reason to believe that institutional service recipients' costs will exceed waiver recipients' for related medical expenses.**

APPENDIX G-8: DEMONSTRATION OF COST NEUTRALITY

LEVEL OF CARE: ICF/MR

Renewal Year	Factor D	Factor D'		Factor G	Factor G'
Year 1 (07/01/03-06/30/04)	\$44,758	\$9,665		\$179,279	\$9,665
	\$54,423		≤	\$188,944	
Year 2 (07/01/04-06/30/05)	\$47,264	\$10,206		\$189,319	\$10,206
	\$57,470		≤	\$199,525	
Year 3 (07/01/05-06/30/06)	\$49,911	\$10,778		\$199,920	\$10,778
	\$60,689		≤	\$210,698	
Year 4 (07/01/06-06/30/07)	\$52,706	\$11,381		\$211,116	\$11,381
	\$64,087		≤	\$222,497	
Year 5 (07/01/07-06/30/08)	\$55,658	\$12,019		\$222,939	\$12,019
	\$67,677		≤	\$234,958	