Independence Plus

1915(c) Waiver Version

A Waiver Program for Family or Individual Directed Community Services

Centers for Medicaid & State Operations

1915(c) Waiver Version

Use for Home & Community-Based Services

Note: This document has not received OMB approval of the information collection pursuant to the Paperwork Reduction Act

Table of Contents

Template for *Independence Plus:* A Demonstration Program for Family or Individual Directed Community Services 1915(c) Waiver Application

I. State Proposal Information

The State of _____ requests approval of a Medicaid Home and Community-Based Services (HCBS) Waiver under the authority of Section 1915(c) of the Social Security Act. The program, to be entitled: _____ will allow Medicaid beneficiaries to arrange and purchase family and individual supports and related services as described below. The proposed effective date of this waiver program is _____. Initial waivers are approved for three years. Renewal waivers are extended for five years.

Line of Authority for Waiver Operation: (**Note**: The State Medicaid Agency is ultimately accountable for the operation of the program, but may allow daily operations to be managed by another entity of State government.) Check one:

_____ The waiver will be operated directly by the _____ Unit of the State Medicaid Agency/Single State Agency.

_____ Operational management and responsibilities of the waiver will be carried out by _____ (another State Agency) and will be subject to an explicit interagency agreement that ensures for accountability and effective management for all requirements and assurances under this waiver. The single State Agency will retain the responsibilities of issuing policies, rules and regulations concerning this waiver. A copy of the interagency agreement setting forth the specific agency responsibilities and authorities is attached and is made pursuant to Section 1902(a) of the Act and 42 regulations at 42 CFR 431.10 which stipulates the roles and responsibilities of the single State Agency.

II. General Description of Program

The purpose of the program is to provide assistance for families with a member who requires long-term supports and services, or to individuals who require long-term supports and services, so that the individual may remain in the family residence or in their own home. Eligibility will be limited to those individuals who require long-term supports at a level typically provided in an institution, as specified in this application.

resources will be identified through an established methodology, open for public inspection, for determining an individual budget that would be based upon actual service utilization data.

fiscal integrity and include participant protections that will be effective and family-friendly. (Additional information, specific to the State administration is included in Appendix A.)

III. Assurances

The State provides the following assurances to CMS:

Health & Welfare - Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards are described in **Appendix B** and include:

A. Adequate standards for all types of providers that furnish services under the waiver;
B. 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. The State assures that these requirements will be met on the date that the services are furnished; and
C. 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 for board and care facilities.

Check one:

_____ Home and Community-Based Services will not be provided in facilities covered by Section 1616(e) of the Social Security Act.

_____ A list of facilities covered by 1616(e) of the Social Security Act, in which HCBS are furnished, and a copy of the standards applicable to each type of facility identified above are also maintained by the Medicaid Agency. These facilities will be used for the limited purpose of:_____
(Note: For example, respite care only when other services are unavailable.)

Financial Accountability - The State will maintain the financial integrity of the HCBS Waiver program. The State will assure financial accountability for funds expended for Home and Community-Based Services, provide for an independent audit of its waiver program, and will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted. **See Appendix G-3**.

Evaluation of Need - The State will provide for an evaluation (and periodic reevaluations, at least annually) of the individuals' need for an institutional level of care, 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 reevaluations are detailed in **Appendix D**.

Choice of Alternatives - When an individual is determined to require a level of care provided in a NF, hospital, or ICF/MR, 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 institutional or Home and Community-Based Services.

The State will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care, or whose services are denied, suspended, reduced or terminated.

Average per capita expenditures - The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care, for which this waiver is an alternative, under the State plan that would have been made in that fiscal year had the waiver not been granted. Cost neutrality is demonstrated in **Appendix G**.

Actual total expenditures - The State's actual total expenditures for Home and Community-Based Services and other Medicaid services under the waiver 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 by the State's Medicaid program for these individuals in the institutional setting(s) for which this waiver is an alternative in the absence of the waiver. Cost neutrality is demonstrated in **Appendix G**.

Services absent the waiver - Absent the waiver, participants would receive the services appropriate to the level of care typically provided in institutional settings available through the State plan.

Reporting - The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the waiver and on the health and welfare of the persons served through the waiver. The information will be consistent with a data collection plan designed by CMS. Reporting is described in **Appendix F-2**

IV. Waivers Requested

Statewideness: The State requests a waiver of the "Statewideness" requirements set forth in Section 1902(a)(1) of the Act.

_____ No. Services will be available Statewide.
_____ Yes. Waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

_____

_____

Comparability: The State requests a waiver of the requirements contained in Section 1902(a)(10)(B) of the Act, to provide services to individuals served on the waiver that are not otherwise available to other individuals under the approved Medicaid State plan.

Income and Resources: The State requests a waiver of 1902(a)(10)(C)(i)(III) of the Social Security Act in order to use institutional income and resource rules for the medically needy.

_____ Yes _____ No _____ N/A

V. State Specific Elements

A. Levels Of Care: This waiver is requested to provide Home and Community-Based Services (HCBS) to individuals who, but for the provision of such services, would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan: (check all that apply)

_____ Hospital
_____ Nursing Facility
_____ ICF/MR

B. Target Population: A waiver of Section 1902(a)(10)(B) of the Act is requested to limit Home and Community-Based Services waiver services to select groups of individuals who would be otherwise eligible for waiver services. The target groups are indicated below:

1. Target group per 42 CFR 441.301(b)(6) – Check all disability and age categories that apply. (**Note:** Current regulations governing 1915(c) waivers do not allow persons under age 65 with mental retardation or developmental disability – and no concurrent physical disability – to be served in a waiver that serves persons with physical disabilities only. Combining populations under the 1115 Demonstration authority is allowable.)

Category	**CHILDREN AGE RANGE**		**ADULTS AGE RANGE**		**AGED AGE RANGE**
	From	**To**	**From**	**To**	**From**
Aged only					
Disabled (Physical)					
Disabled (Other)					
Brain Injury (Acquired)					
Brain Injury (Trauma)					
HIV/AIDS					

Medically Fragile					
Technology Dependent					
Autism					
Developmental Disability					
Mental Retardation					
Mental Illness					

2. States have the discretion to further define these target groups. If the State wishes to further define, please describe below:

_____
_____
_____
_____

3. The State selects the following option regarding individual cost limits:

_____ A. No otherwise eligible individual will be denied services or enrollment in the waiver solely because the cost of the individual's Home and Community-Based Services exceeds the average institutional Medicaid payment for the applicable level of care.

_____ B. Otherwise eligible individuals may be denied home or community-based services if the agency reasonably expects that the cost of the Home and Community-Based Services would exceed the cost of an equivalent and applicable level of institutional care, pursuant to 42 CFR 441.301(a)(3). The State selects the following method to calculate these costs:

_____ **Individualized Computation.** The Medicaid cost of the individual's service plan is compared to the cost of serving *this particular individual* in the institutional setting.

_____ **Mathematical Average.** The Medicaid cost of the individual's service plan will be compared to the state's average per capita cost of applicable institutional care at _____ 100% of the institutional average or a level higher than 100% (_____%). Further, the limit will be calculated on the basis of:

_____ **1) Level of care**

_____ **2) Diagnosis or condition**

C. Medicaid Eligibility: All eligibility groups included under this waiver are covered in the State plan. The State will apply all applicable FFP limits under the plan.

1. ***Eligibility Criteria***: Specify whether your State uses the eligibility criteria used by the Supplemental Security Income (SSI) program or whether it uses more restrictive eligibility criteria than those of the SSI program for aged, blind, and disabled individuals: (check one):

   ____ SSI Criteria or 1634 State. The State uses SSI criteria.

   ____ 209(b) State. The State uses more restrictive eligibility criteria for aged blind, and disabled individuals than the criteria used under the SSI program.

2. ***Eligibility Groups Served*:** Individuals receiving services under this waiver are eligible for Medicaid under the following eligibility groups: (check one):

   a. _____All eligibility groups covered in the State plan are included under this waiver.
   b. _____Only the following groups covered under the State plan are included under this waiver. (Check all that apply)

   1. _____ Low-income families with children as described in Section 1931 of the Social Security Act
   2. _____ SSI Recipients
   3. _____Aged, blind or disabled who are eligible under 42 CFR 435.121
   4. _____ Medically needy (A waiver of Section 1902(a)(10)(C)(i)(III) of the Social Security Act is requested to use institutional income and resource rules for the medically needy.)
   5. _____ All other optional and mandatory groups under the plan except for those individuals who would be eligible for Medicaid only if they were in an institution).
   6. _____ Individuals who <u>would</u> be eligible for Medicaid only if they were in an institution
   7. _____ Individuals who would only be eligible for Medicaid, without spend down income, if they were living in a hospital, NF or ICF/MR. (Check one)
      _____ All Individuals
      _____ Limited to:
      A special income level equal to:
      _____300% of the SSI Federal Benefit Rate (FBR), <u>OR</u>
      _____ %, a percentage lower than 300% of FBR, <u>OR</u>
      $____, a specific amount that is lower than 300% of FBR
      _____ Aged blind and disabled who meet requirements that are more restrictive than those in the SSI program

(Please explain:_____
_____
_____ Medically needy without spend down
_____ Other: _____

3. Spousal Impoverishment Protection: Spousal impoverishment rules may be used for determining eligibility for the special Home and Community-Based Waiver eligibility group at 42 CFR 435.217 for individuals who have a spouse residing in the community. Further, these rules may apply to the post-eligibility treatment of income.

The State will use spousal impoverishment rules for determining income:
____ Yes ____ No

The State will use spousal impoverishment rules for the post-eligibility treatment of income:
_____ Yes _____ No

D. Services: The State requests that the following Home and Community-Based Services, as set forth in 42 CFR 440.180, be included under this waiver (Check all that apply here and define in **Appendix B**): (**NOTE:** All services must meet applicable regulatory standards and CMS policy guidance. Refer to **Appendix B** for new self-directed service descriptions.)

Check all that apply:

Service	Family or Individual Directed Method	Provider or Other Service Delivery Method
Case Management		
Homemaker Services		
Home Health Aide Services		
Personal Care Services (may include Attendant Care)		
Adult Day Health Services		
Habilitation Services		
Respite Services		
Supports Brokerage Services/Functions (Required)		
Fiscal/Employer Agent Services/Functions (Required)		
Other (Describe in Appendix B)		

VI. Cost neutrality

The State has provided the supporting information/data to demonstrate cost neutrality in **Appendix G**.

VII. Additional Requirements

A. Plan Of Care: A written plan of care will be developed for each individual under this waiver utilizing a family or person-centered planning process that reflects the needs and preferences of the individual and their family. The State's procedures governing the plan of care and the utilization of family or person-centered planning are included in **Appendix E**.

(**Note**: Family or person-centered planning is a process, directed by the family or the individual with long-term care needs, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The family or individual directs the family or person-centered planning process. The process includes participants freely chosen by the family or individual who are able to serve as important contributors. The family or person-centered planning process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally-defined outcomes in the most inclusive community setting. The individual identifies planning goals to achieve these personal outcomes in collaboration with those that the individual has identified, including medical and professional staff. The identified personally-defined outcomes and the training, supports, therapies, treatments and/or other services the individual is to receive to achieve those outcomes become a part of the plan of care.)

All services will be furnished pursuant to a written plan of care.

This plan of care will describe the services and supports (regardless of funding source) to be furnished, their projected frequency, and the type of provider who will furnish each.

The plan of care will address how potential emergency needs of the individual will be met.

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 or services that are not included in the individual written plan of care.

B. Individual Budgets:

(**NOTE:** Individual budgets include the value of the waiver services available to the family or individual to support the individual's plan of care. Only waiver services as defined by the State are included in the individual budget. This amount of money designated in the budget is established by a methodology determined by the State and the amount is agreed upon with the family or individual.)

Check one:

_____ The State has established a uniform methodology by which all individual budgets in the State will be calculated. The methodology is described in **Appendix H**. (**Note**: Minimum requirements of the methodology are that the budget is built upon actual service utilization and cost data, the methodology is described to the individual and their family, the methodology is open for inspection by authorized public entities including, but not limited to CMS, and there is a process for re-determination.)

_____ The State has established a minimum set of criteria and an approval process for methodologies developed by subcontractors, counties or other entities with which the State has contracted for the day-to-day operation of the waiver. The criteria by which individual budget methodologies will be reviewed and the approval process is described in **Appendix H**. (**Note**: Minimum requirements of the methodology are that the budget is built upon actual service utilization and cost data, the methodology is described to the individual and their family, the methodology is open for inspection by authorized public entities including, but not limited to, CMS, and there is a process for re-determination. Although the Medicaid Agency may contract with another agency or organization for the daily operation of the waiver program, it must retain the authority to issue policies, rules and regulations related to the waiver.)

C. Provider Selection: Families and individuals will have flexibility to select qualified providers of their choosing within the criteria established by the State. The criteria are described in **Appendix B.**

D. Plan Of Care Management: Families and individuals will have the ability to direct the services and supports identified in the plan of care within the resources available in the established individual budget. Families will have maximum possible flexibility in the utilization of resources delineated in the plan of care and individual budget. The State's description of how families may flexibly use resources while the State continues to assure health and welfare is described in **Appendix E**.

(Note: As determined by the state, families and individuals may have the ability to move resources among and between all or some of the services contained in the plan of care without a formal plan of care revision. Families or individuals might have full discretion

to manage all of the plan or only parts of it. For example, the family or individual might manage the homemaker services, but not the habilitation services.)

E. Participant Protections: The State assures that each of the protections below is in place and described in **Appendix I**.

The State has procedures to assure that families have the requisite information and/or tools to participant in a family or person-centered planning approach and to direct and manage their care as outlined in the individual plan of care. The State will make available and provide services such as assistance in locating and selecting qualified workers, training in managing workers, completing and submitting paperwork associated with billing, payment and taxation. Supports Brokerage and Fiscal/Employer Agent Services/Functions are required and should be provided by one or more entities. The services and the provider qualifications are described in **Appendix B**.

Upon family or individual request, the State makes available, at no cost, provider qualification checks, including criminal background checks. (Note: Provider qualifications for each service are described in **Appendix B**.)

The State has procedures to promote family and individual preferences and selections and these are appropriately balanced with accepted standards of practice. This balance requires deference to the individual whenever possible. Procedures will include individual risk management planning (e.g., risk agreements or informed consent contracts) to ensure that family or individual decisions are honored.

The State has a viable system in place for assuring emergency back-up and/or emergency response capability in the event those providers of services and supports essential to the individual's health and welfare are not available. While emergencies are defined and planned for on an individual basis, the State also has system procedures in place.

The State has procedures for how it will work with families or individuals and their fiscal/employer agents (if applicable) to monitor the ongoing expenditure of the individual budget.

The State has procedures for how it will handle those instances where this ongoing monitoring has failed to prevent the expenditure of the individual budget in advance of the re-determination date to assure that services needed to avoid out-of-home placement and the health and welfare of the individual are available.

The State has procedures for how decisions will be made regarding unexpended resources at the time of budget re-determination.

F. Quality Assurance & Improvement:

The State, through an organized quality assurance program, will provide appropriate oversight and monitoring of its HCBS Waiver program to ensure that each of the

assurances contained in this application is met and to continually improve the operation of the program. The program will involve families or individuals in the process of assessing and improving quality. Details of this process are found in **Appendix F** of this request. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with their severity and nature and will contain an incident management system to address critical events.

G. Contact Person: The State Medicaid Agency Representative that CMS may contact with questions regarding the waiver request is:

Name:

Title:

Agency:

Address:

Telephone:

E-mail:

H. Authorizing Signature: This document, together with Appendices A through I, and all attachments, constitutes the State's request for a *Independence Plus:* A Demonstration Program for Family or Individual Directed Community Services Home and Community-Based Services Waiver under Section 1915(c) of the Social Security Act. The State affirms that it will abide by all 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-Based 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.

(**Note:** The request must be signed by the Governor, Single State Agency or Medicaid Director, or a person within the State Medicaid Agency with the authority to sign on behalf of the State.)

Signature:
Print Name:
Title:
Date:

APPENDIX A – DESCRIPTION OF THE WAIVER PROGRAM

(**Note:** The state must provide a narrative description of the waiver program beyond the general description above. This includes the intended purposes of the waiver.)

APPENDIX B - SERVICE DEFINITIONS, STANDARDS AND PROVIDER QUALIFICATIONS

A. SERVICE DEFINITIONS, STANDARDS & PROVIDER QUALIFICATIONS CHARTS

For each service that was checked under State Specific Elements/Services of the template, the following chart must be completed. Each chart provides the State's service definition, outlines the provider qualifications and standards, and the service delivery method that govern the provision of each service under the waiver.

Provider qualifications would be expected to vary by the type of service being provided or managed. For those services for which there is a uniform State license or certification requirement, the legal citation is provided. For State defined standards other than those governed by State law, the standards are attached. Either the family or individual and the State Agency may manage some services. For example, the family or individual might have self-directed support services which include personal care type arrangements. The State may also have personal care services provided by an agency. The provider requirements might be different under these two arrangements. However, the differences must be explained.

For those services that are available in the State plan, the description must include those aspects of the service that go beyond the State plan coverage. (**Note:** For example, if personal care services are included in the State plan, personal care services provided under the scope of the waiver must differ in amount, scope, supervision arrangements or provider type **or** be utilized only when the state plan coverage is exhausted.)

The State has the authority to request that the Secretary approve "other" services identified by the State as cost neutral and appropriate to avoid institutionalization. Each "other" service defined by the State must be separately identified and defined and include the provider qualifications.

Service/Function Definitions Not Described Elsewhere:

> ***Supports Brokerage:*** Service/function that assists participating families and individuals to make informed decisions about what will work best for them, are consistent with their needs and reflect their individual circumstances. Serving as the agent of the family or participant, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. A family or person-centered planning approach is used. Supports Brokerage offers practical skills training to enable families and individuals to remain independent. Examples of skills training include providing information on recruiting and hiring personal care workers, managing personal care workers and providing information on effective communication and problem-solving. The service/function provides sufficient information to assure that participants and their families understand the responsibilities involved with self direction and assist in the development of an effective back-up and emergency plan. States may elect to fulfill the requirement

of this service/function using a self-directed case manager or creating a distinct service. States may elect to fulfill this required service/function either as a service cost or an administration cost, but must clearly identify which method will be used. The services/functions included in Supports Brokerage are mandatory requirements of the template.

Fiscal/Employer Agent: Service/function that assists the family or individual to manage and distribute funds contained in the individual budget including, but not limited to, the facilitation of the employment of service workers by the family or individual, including Federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports, etc. States may elect to fulfill this required service/function either as a service cost or an administration cost, but must clearly identify which method will be used. This service/function, regardless of provider or method, must be delivered under a family or person-centered planning process and is a requirement of the template.

Other Services: Services appropriate to ensure the health and welfare of individual participants and, in conjunction with other services, serve as an alternative to institutionalization.

Service Title	
Service Definition	
Provider Requirements	
State License	
Certification	
Other Requirements or Standards	
Describe Service Delivery Method (Agency or Self-directed)	

B. ASSURANCES THAT REQUIREMENTS ARE MET

1. 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.

2. The State assures that each service furnished under the waiver is cost-effective (compared to the cost of institutional care) and necessary to prevent institutionalization. Cost effectiveness is demonstrated in Appendix G.

C. 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 C – INTENTIONALLY LEFT BLANK

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

Persons performing initial evaluations of level of care for waiver applicants will have the following educational/professional qualifications:

b. PROCESS FOR LEVEL OF CARE DETERMINATION

The following describes the process for evaluating and screening waiver applicants to determine level of care:

c. CONSISTENCY WITH INSTITUTIONAL LEVEL OF CARE
The State will use the following methods to ensure that level of care determinations used for the waiver program are consistent with those made for institutional care under the State plan:

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at least annually) according to the following schedule:

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Persons performing reevaluations of level of care will have the following qualifications:

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care:

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s):

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 attached to this Appendix. If this instrument differs from the form used to evaluate or assess institutional level of care, a description of how and why it differs and an assurance that the outcome of the determination is reliable, valid, and fully comparable is attached.

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care provided in an institutional setting, 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 institutional or Home and Community-Based services.

PROCESS: The following describes the agency's procedure(s) for informing eligible individuals of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver 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 or who are denied the service(s) of their choice, or the provider(s) of their choice.

PROCESS: The following describes the process for informing eligible individuals of their right to request a fair hearing under 42 CFR Part 431, Subpart E:

b. FREEDOM OF CHOICE DOCUMENTATION

1. A copy of the form(s) used to document freedom of choice and to offer a fair hearing is attached to this Appendix.

2. Copies of free choice documentation are maintained in the following location(s): _____.

APPENDIX E - PLAN OF CARE

APPENDIX E-1 - PLAN OF CARE DEVELOPMENT/MAINTENANCE

1. The attached policy and procedures define and guide the family or person-centered planning process and assure that families are integrally involved in the plan development and that the plan of care reflects their preferences, choices, and desired outcomes.

2. The following individuals are responsible for the preparation of the plans of care: _____.

3. Copies of written plans of care will be maintained for a minimum period of 3 years in the following location(s):

4. 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, and responsive to the individual's needs and preferences. The minimum schedule under which these reviews will occur is:

5. If the State uses a standardized plan of care document, a copy of this form should be submitted.

APPENDIX E-2 – 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.

APPENDIX E-3 – PLAN OF CARE MANAGEMENT

The following is a description of process and parameters within which families or individuals have flexibility to utilize resources identified within the plan of care and the individual budget that do not necessitate a formal revision to the plan of care. In addition, the State's infrastructure to support families or individuals in directing and managing their plan of care is described here.

APPENDIX F – QUALITY ASSURANCE AND IMPROVEMENT

APPENDIX F-1 - QUALITY ASSURANCE & IMPROVEMENT PROGRAM

A description of the State's quality assurance and improvement program is attached. This description includes State policies and procedures which describe the:

1) frequency of quality assurance activities;
2) domains/dimensions/assurances that will be monitored (e.g., access, person-centered service planning, provider capacity and capabilities, participant safeguards, participant rights, participant outcomes and satisfaction, etc.);
3) process of discovery (including sampling methodologies and whether or not information is collected from interviews with families/individuals in their community residences);
4) identification of the persons responsible for conducting quality assurance activities and their qualifications (including how families and individuals will be involved in the process of assessing and improving quality);
5) provisions for periodically reviewing and revising its quality assurance policies and procedures when necessary;
6) provisions for assuring that all problems identified by the discovery process will be addressed in an appropriate and timely manner, consistent with the severity and nature of deficiencies and
7) system to receive, review and act upon critical events or incidents.

APPENDIX F-2 ANNUAL REPORTS

A summary of the results of the State's monitoring of recipient health and welfare and the continuous improvement of waiver program operations will be submitted annually, as part of the CMS approved reporting forms/process.

APPENDIX G – FINANCIAL DOCUMENTATION

APPENDIX G-1
COMPOSITE OVERVIEW AND DEMONSTRATION OF
COST NEUTRALITY FORMULA

LEVEL OF CARE: _____

Definitions:

(NOTE: A separate chart should be filled out for every level of care in the waiver program. The State should also include a chart reflecting the weighted average of the combined levels of care offered in the program.)

Factor D Estimated annual average per capita Medicaid cost for Home and Community-Based Services for individuals in the waiver program.

Factor D' Estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program

Factor G Estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted.

Factor G' Estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Col. 1 Year	**Col. 2 Factor D**	**Col. 3 Factor D'**	**Col. 4 Total: D+D'**	**Col. 5 Factor G**	**Col. 6 Factor G'**	**Col. 7 Total: G+G ?**	**Col. 8 Difference (subtract column 4 from column 7)**
1							
2							
3							
4							
5							

If states elect to consider Supports Brokerage and/or Fiscal/Employer Agent Services/Functions administratively rather than as wavier services, these costs and the methodology used to calculate the costs must be identified.

Service	Estimated Costs	Methodology Description
Supports Brokerage		
Fiscal/Employer Agent		

APPENDIX G-2 - DERIVATION OF ESTIMATES

NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS	EXPLANATION of ESTIMATE of NUMBER of UNDUPLICATED INDIVIDUALS SERVED:
1		
2		
3		
4		
5		

FACTOR D: AVERAGE COST OF WAIVER SERVICES

Waiver Service (Add row for each service)	# Users	Avg. Units/User	Avg. Cost/Unit	Total Cost
1				
2				
3				
4				
5				
GRAND TOTAL:				
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				
FACTOR D (Divide total by number of recipients)				

PROJECTED AVERAGE LENGTH OF STAY IN WAIVER PROGRAM:

_____

Please provide a narrative description and supporting documentation for the derivation of the following factors:

FACTOR D DERIVATION:

FACTOR D' DERIVATION:

FACTOR G DERIVATION:

FACTOR G' DERIVATION:

Appendix G-3 METHOD OF PAYMENTS (check one):

____ Payments for all waiver and 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 make payments and maintain an audit trail is attached to this Appendix.

_____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which the State will make payments and maintain an audit trail is attached to this Appendix.

Appendix G-4 – INDIVIDUAL BUDGET PROJECTIONS OF RESOURCES WITHIN THE EXCLUSIVE CONTROL OF THE FAMILY OR THE INDIVIDUAL. (This information is required, but will not be used in the calculations of cost neutrality.)

Please estimate the proportion of families or persons who will have annual individual budget amounts in the following ranges:

Budget Range	Proportion of Participants
$1 – 5,000	
$5001 – 10,000	
$10,000 – 15,000	
$15,001 – 20,000	
$20,001 – 25,000	
$25,001 – 50,000	

$50,000 – 75000	
$75,001 – 100,000	
$100,000 and above	
	100%

APPENDIX H – INDIVIDUAL BUDGETS

The following describes in detail EITHER:

The State's uniform methodology for the calculation of individual budgets, OR

The criteria and approval process for entities with which the State has contracted for day-to-day operations of the program.

This description addresses the minimum requirements that the methodology utilize actual service utilization and cost data, how the methodology is explained to the family or individual, the re-determination process, and how the methodology is open to public inspection.

APPENDIX I – PARTICIPANT PROTECTIONS

The State procedures and processes to assure that each of the following protections is in place are described below.

The State has procedures to assure that families and individuals have the requisite information and/or tools to participate in a family or person-centered planning approach and to direct and manage their care as outlined in the individual plan of care. The State will make available and provide services such as assistance in locating and selecting qualified workers, training in managing the workers, completing and submitting paperwork associated with billing, payment and taxation. Such functions are mandatory under the template and should be provided by one or more entities. The services and the provider qualifications are described in Appendix B.

Upon family or individual request, the State makes available at no cost, provider qualification checks, including criminal background checks.

The State has procedures to promote family or individual preferences and selections and these are appropriately balanced with accepted standards of practice. This balance requires deference to the individual whenever possible. Procedures will include individual risk management planning (e.g., risk agreements or informed consent contracts) to ensure that family or individual decisions are honored.

The State has a viable system in place for assuring emergency back up and/or emergency response capability in the event those providers of services and supports essential to the individual's health and welfare are not available. While emergencies are defined and planned for on an individual basis, the State also has system procedures in place.

The State has procedures for how it will work with families and their employer agents (if applicable) to monitor the ongoing expenditures of the individual budgets.

The State has procedures for how it will handle those instances where this ongoing monitoring has failed to prevent the expenditure of the individual budget in advance of the re-determination date to assure that services needed to avoid out-of-home placement and the health and welfare of the individual are available.

The State has procedures for how decisions will be made regarding unexpended resources at the time of budget re-determination.

The State has a viable system by which it receives, reviews and acts upon critical events or incidents (states must describe critical events or incidents). This system

may include an existing process (e.g. child or adult protective services). This system must be part of the Quality Assurance and Improvement Program.