

**Application for
1915(c) HCBS Waiver: NJ.0032.R05.00 -
Oct 01, 2011**

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Waiver NJ.0032.R05.00

Program Title:

Global Options for Long-Term Care (GO) Waiver

Type of Request:

renewal - 5 years

Original Base Waiver Number:

NJ 0032

Waiver Type:

Regular Waiver

Approved Effective Date:

Oct 1, 2011

Application Status:

APPROVED

Draft ID: NJ.20.05.00

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Deactivate	
<input type="button" value="Create Amendment"/>	<input type="button" value="Create Renewal"/>

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
The following changes are being made to the Global Options for Long-Term Care (GO) Waiver:

1. Points of clarification to the service definitions of three waiver services (Respite, Environmental Accessibility Adaptations, and Transitional Care Management) have been made to ensure the appropriate scope of the services are defined, and to specify applicable limits on the amount, frequency, or duration of these services. These modifications are detailed in Appendix C of the renewal document.
2. The provider qualifications of Care Managers were modified nominally.
3. Emphasis was made in Appendix C-4 and Appendix D-1d to clarify that all authorized services, which are identified in the GO participants Plans of Care, are based on each individual's assessed needs. A need based care allocation tool is utilized to assist Care Managers in determining a GO participant's care needs when developing the initial Plan of Care, the annual Plan of Care or when there has been a significant change in the participant's functional abilities or a significant change in caregiver status requiring a revision to the Plan of Care. The needs based care allocation tool assists the state in demonstrating that services available are equal in amount, duration, and scope for all GO participants based on their individual assessed needs.
4. New Jersey has submitted a 1915(b) waiver to mandatorily enroll the aged, blind and disability populations, as well as individuals with dual eligibility (Medicare/Medicaid) into managed care. That waiver is pending approval with CMS.

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

1. Request Information (1 of 3)

- A. The State of New Jersey requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Global Options for Long-Term Care (GO) Waiver
- C. **Type of Request:** renewal

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

3 years 5 years

 Migration Waiver - this is an existing approved waiver Renewal of Waiver:

Provide the information about the original waiver being renewed

Base Waiver Number: 0032

Amendment Number

(if applicable):

Effective Date: (mm/dd/yy) 10/01/83

Waiver Number: NJ.0032.R05.00

Draft ID: NJ.20.05.00

Renewal Number: 05

D. Type of Waiver (select only one):

Regular Waiver

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

10/01/11

Approved Effective Date: 10/01/11

1. Request Information (2 of 3)

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

 Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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

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

Select applicable level of care

Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155

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

The State does not additionally limit the Waiver to subcategories of the nursing facility level of care.

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140 Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)

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

1. Request Information (3 of 3)

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

Select one:

Not applicable**Applicable**

Check the applicable authority or authorities:

- Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- Waiver(s) authorized under §1915(b) of the Act.**

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

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

- §1915(b)(1) (mandated enrollment to managed care)**
- §1915(b)(2) (central broker)**
- §1915(b)(3) (employ cost savings to furnish additional services)**
- §1915(b)(4) (selective contracting/limit number of providers)**
- A program operated under §1932(a) of the Act.**

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

- A program authorized under §1915(i) of the Act.**
- A program authorized under §1915(j) of the Act.**
- A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

Goal: The goal of the Global Options for Long-Term Care (GO) Medicaid Waiver is to enable individuals 65 years of age and older and physically disabled persons between 21 years of age and 64, who are assessed as needing nursing facility level of care and who meet financial requirements, to remain living in the community or return from institutional care to the community through the provision of health care and supportive services delivered in the individual's home, Assisted Living Residence, Comprehensive Personal Care Home, Assisted Living Program in Subsidized Housing, Adult Family Care Home, or Class B Boarding Home.

Objectives:

- Provide nursing facility level of care evaluations for individuals for whom there is a reasonable indication that Global Options for Long-Term Care services is necessary in order to transition from or avoid institutionalization.
- Develop a Plan of Care for each Global Options for Long-Term Care participant based upon a comprehensive evaluation that promotes participant direction (including hiring one's own employee), considers the participant's goals, preferences, and risk factors, utilizes formal and informal service providers, and involves input from the participant and/or the participant's representative/legal representative.
- Provide services to Global Options for Long-Term Care participants utilizing qualified providers.
- Protect the general health and well being of Global Options for Long-Term Care participants.
- Maintain and improve State administrative structures, policies and procedures to assure Global Options for Long-Term Care program integrity and fiscal accountability.

Organizational Structure: In accordance with Executive Reorganization Plan No. 001-1996, the New Jersey Department of Health and Senior Services (DHSS)' Division of Aging and Community Services will operate the Global Options for Long-Term Care Medicaid Waiver. The operating agency is accountable to the single State Medicaid Agency, the Division of

Medical Assistance and Health Services (DMAHS), housed in a separate agency, the New Jersey Department of Human Services (DHS).

Under the Executive Reorganization Plan, as defined in the subsequent Interagency Agreement, the Department of Health and Senior Services will exercise discretion in the administration and supervision of Global Options for Long-Term Care. A copy of the Interagency Agreement, setting forth the authority and terms of this Executive Reorganization Plan, is on file at the State Medicaid Agency. Currently DHSS & DHS have established internal review committees to update the Interagency Agreement to reflect the new business processes, collaborative working relationships and the administrative responsibilities; oversight and monitoring to ensure all federal assurances are met. At the conclusion of DHSS' review of the existing Interagency Agreement, DHSS will schedule a meeting with the DHS to go through and discuss the revised draft for review and approval by the Director of the Division of Medical Assistance and Health Services and the Assistant Commissioner of the Division of Aging and Community Services. The target date for review and approval by the Medicaid Director and DACS Assistant Commissioner is October 2011. The Interagency Agreement will then be forwarded to the DHSS and DHS Commissioners for final authorization, which is projected to occur by February 2012.

Medicaid Agency Oversight: The Quality Management Unit (QMU) of the New Jersey Department of Human Services' Division of Medical Assistance and Health Services has developed a systematic approach to the continuous improvement in the provision of Home and Community-Based Services that builds upon the State Operating Agency's quality assurance systems. DMAHS/QMU has responsibility for the Quality Oversight of all waiver assurances through Comprehensive Audits, Interim Targeted Audits, and analysis of aggregate data to develop system-wide quality improvement changes utilizing specific Topic Audit(s).

Service Delivery Methods: Each Global Options for Long-Term Care participant is assigned a Care Manager who is responsible for working with the participant or his or her representative/legal representative to develop a Plan of Care, based upon a comprehensive assessment. In the Plan of Care, the participant identifies his or her needs, goals and preferences. Risk factors are identified and back up plans created to respond to risk factors. The Care Manager and participant work together to select those services that can best meet these needs, goals and preferences, and address the risk factors. The Care Manager and participant also work together to choose both formal and informal service providers from among those qualified to deliver Medicaid and other community services to the participant. Participants are offered the opportunity to hire their own employee(s). This collaboration includes designing how services will be delivered. The Care Manager arranges for service delivery with formal and informal providers selected by the Global Options for Long-Term Care participant and monitors services to verify delivery and assure consumer satisfaction. Plans of Care are modified based upon participant re-evaluations, in response to a change in the participant's condition, or a change in the availability of informal supports. The Global Options for Long-Term Care Medicaid Waiver reimburses approved service providers either by utilizing traditional fee-for-service payment methods or through a Fiscal Intermediary for non-traditional providers or Participant Employed Providers of waiver Services.

3. Components of the Waiver Request

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

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

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

No. This waiver does not provide participant direction opportunities. Appendix E is not required.

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

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable
- No
- Yes
- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):
- No
- Yes

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

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial

hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

The Global Options for Long-Term Care quality assurance process includes bi-annual participant satisfaction surveys conducted through mass mailings to program participants and/or their representatives/legal representatives. Also, during on-site quality assurance visits to care management agencies, program participants are selected for in-home face-to-face interviews conducted by Division of Aging and Community Services staff. The results of these surveys are analyzed and aggregated to identify trends, concerns and suggestions to improve the program. Care Managers and care management agency administrators are also interviewed during the on-site survey process and the results of these interviews have been considered to improve the program in general as well as the quality assurance process.

In addition, the Division of Aging and Community Services' Office of Long Term Care Programs representatives meet with the Medical Assistance Advisory Council and the Medicaid Long Term Care Funding Advisory Council, created by the June 2006 Independence, Dignity and Choice in Long-Term Care Act, on an ongoing basis; as well as at periodic Systems Transformation State Management Team meetings. Input from consumer and professional members of these standing Councils are considered with regard to GO Waiver Renewal.

GO Waiver Policy and Program Operations are also continually referenced and discussed at Area Agency on Aging Executive Directors meetings, Care Coordinators and Care Management Supervisors quarterly meetings, and bi-annual Care Management Regional Meetings hosted by the Division of Aging and Community Services' Quality Assurance Unit staff, Interdivisional Waiver Committee meetings, as well as periodically at the Medicaid Directors and Supervisors of the County Welfare Agencies meetings.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.**K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.**7. Contact Person(s)****A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail: Meredith.VanPelt@dhs.state.nj.us

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

Last Name: Day

First Name: Nancy

Title: Assistant Commissioner

Agency: NJ Department of Health and Senior Services, Division of Aging and Community Services

Address: 240 West State Street

Address 2: P.O. Box 807

City: Trenton

State: New Jersey

Zip: 08625-0807

Phone: (609) 943-3428 Ext: TTY

Fax: (609) 943-3343

E-mail: Nancy.Day@doh.state.nj.us

8. Authorizing Signature

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

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

Signature: Valerie Harr
State Medicaid Director or Designee

Submission Date: Jan 10, 2012

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

Last Name: Harr

First Name: Valerie

Title: Director
Agency: NJ Department of Human Services, Division of Medical Assistance and Health Services
Address: 7 Quakerbridge Plaza
Address 2: P.O. Box 712
City: Trenton
State: New Jersey
Zip: 08625-0712
Phone: (609) 588-2600 Ext: TTY
Fax: (609) 588-3583
E-mail: Valerie.J.Harr@dhs.state.nj.us

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

A transition plan is not necessary for the GO for Long-Term Care Waiver. Upon renewal, operations and administration of this waiver remain the same.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the State Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

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

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has

been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

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

Specify the division/unit name:

New Jersey Department of Health and Senior Services

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

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

The Division of Medical Assistance and Health Services established a Quality Management Unit (QMU) in its Office of Provider Relations to provide oversight of the State Operating Agency's implementation of its Waivers to assure compliance with the Centers for Medicare and Medicaid Services Quality Assurance measures and to prioritize problematic aspects of the service delivery system. A designated QMU Lead Liaison is assigned to the Division of Aging and Community Services to coordinate and oversee the development and finalization of the Waiver audit process and reports findings directly to the Quality Management Unit Healthcare Administrator. The Quality Management Unit Clinical Lead Liaison assigned to the Division of Aging and Community Services attends the Division's quarterly and semi-annual regional meeting with specified waiver service providers. The Quality Management Unit oversight and monitoring responsibilities encompass scheduled annual comprehensive desk audits, interim targeted desk and on-site audits on an as-needed basis, quarterly topic audits, collection and analysis of aggregate data, and the monitoring of trends. The focus of the topic audits will be determined annually and conducted through quarterly reviews. Audits will include a review of the level of care determinations and re-evaluations of level of care for accuracy, the responsiveness of plans of care to participant needs identified in the evaluations and re-evaluations, the assurance that individuals receive services from qualified providers, that the health and welfare of Waiver participants is addressed, and fiscal accountability is assured for the services rendered.

In addition, the Division of Medical Assistance and Health Services (DMAHS) utilizes the following methods to ensure that the Division of Aging and Community Services (DACS) meets Waiver requirements in its operational and administrative functions. The Division of Medical Assistance and Health Services reviews and approves annual 372 reports; reviews, has input into, and approves all State Plan Amendments, Waiver renewals, amendments, and Interim Procedural Guidance progress reports; reviews the Division of Aging and Community Services quarterly and annual reports of aggregated data from internal audits to ensure compliance

with Waiver assurances; and annually reviews and has input into modification of the Division of Aging and Community Services Quality Management Strategy.

The Division of Medical Assistance and Health Services (DMAHS) - Quality Management Unit (QMU) oversight and monitoring responsibilities encompass annual comprehensive audits, interim target audits and topic audits which include collection and analysis of aggregate data and monitoring trends. Topic audit(s) are selected and conducted at least once during the waiver period and are based on the findings from the comprehensive and interim target audits aggregated data. The purpose is to establish system-wide changes for quality improvement for all of the state waivers in collaboration with DMAHS/QMU, Division of Aging and Community Services (DACS), and all of the State Operating Agencies. Audits will include a review of the level of care determinations and re-evaluations of level of care for accuracy, the responsiveness of plans of care to participant needs identified in the evaluations and re-evaluations, the assurance that individuals receive services from qualified providers, that the health and welfare of Waiver participants is addressed, and fiscal accountability is assured for the services rendered.

Appendix A: Waiver Administration and Operation

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

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

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

Accredited Registered Homemaker Agencies, Licensed Certified Home Health Agencies, Licensed Adult Family Care Sponsor Agencies, and approved proprietary or not-for-profit Care Management entities serve as Care Management Agencies and conduct level of care re-evaluations. Care Management Agency Supervisors provide Staff training, review and approve re-evaluations, and review and approve service plans/Plans of Care.

A fiscal intermediary, is contracted by DACS as Financial Management Services (FMS) to act as an agent for the participant/employer in performing fiscal responsibilities associated with processing payroll and withholding obligations. The Financial Management Services assists participants in verifying participant-employed participant's worker citizenship status, collects and processes timesheets of Participant-Employed Providers, processes payroll, withholding, filing and payment of applicable federal, State and local employment-related taxes and insurance, and is also under contract to: develop a Participant-Employed Provider Manual; Develop a Provider Instructional Manual; Participate in/provide training sessions for Care Managers and Division of Aging and Community Services Staff; provide Options Counseling as a services; provide technical assistance to providers regarding billing/payment issues; and establish a quality assurance program to monitor the performance of itself, providers, and participants in the accuracy and timeliness of completing required tasks and procedures associated with Home and Community-Based Waiver programs. In addition, the Financial Management Services provides customer services to Participant-Employed Providers and their employees re: timesheet/paperwork completion and submission; support to Care Managers, assistance to Participant-Employed Providers, to resolve claim discrepancies, verification that claims are paid in accordance with applicable Individual Service Agreements, and provides year end tax information to employers and Participant-Employed Providers. Also, the Fiscal Intermediary notifies all providers when claims are pended, reviews the pended claim file for follow-up on problem resolutions, and issues payments to providers if approved through the Division of Aging and Community Services (DACS) Database.

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

Appendix A: Waiver Administration and Operation

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

Not applicable

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

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

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

Both the Area Agencies on Aging (AAA) (part of county government in New Jersey) and County Welfare Agencies (CWA) disseminate information regarding the Waiver to potential enrollees and assist individuals with Waiver enrollment. Both agencies provide Care Management for Global Options for Long-Term Care participants and perform level of care re-evaluations. Care Management Supervisors in these agencies provide Staff training, review and approve level of care re-evaluations conducted by Care Managers, and review and approve service plans. The Area Agencies on Aging and County Welfare Agencies have separate agreements with the Division of Aging and Community Services to perform Care Management Functions. Each Area Agency on Aging and County Welfare Agency is also enrolled through Molina, the State's fiscal agent, as a Medicaid provider of Care Management.

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

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

Medicaid enrolled Accredited Registered Homemaker Agencies, Licensed Certified Home Health Agencies, Licensed Adult Family Care Sponsor Agencies, proprietary or not-for-profit Care Management Entities, provide Care Management for Global Options for Long-Term Care participants and perform level of care re-evaluations. Care Management Supervisors in these agencies provide Staff training, review and approve level of care re-evaluations, and review and approve service plans. Each of the Care Management entities mentioned in this section, have agreements with the Division of Aging and Community Services to provide Care Management Services. In addition, each Care Management entity is also enrolled through the State Fiscal Agent as a Medicaid provider of Care Management.

Non-traditional providers of Waiver services, i.e., Chore Services, Community Transition Services, Environmental Accessibility Adaptations, Home-Based Supportive Care, Home-Delivered Meal Service, Personal Emergency Response System, Specialized Medical Equipment and Supplies, and Transportation, all have a written agreement with the Department of Health and Senior Services to provide the specific service(s) for which they are eligible because they have met the standards for participation.

Appendix A: Waiver Administration and Operation

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

The State Contractor in the Department of Treasury, Division of Purchase and Property, Purchase Bureau is responsible for assessing the performance of the Waiver's Financial Management Services.

The Division of Aging and Community Services is responsible for assessing the performance of all care management agencies that are responsible for participant level of care re-evaluations and service plan approvals. The Division of Aging and Community Services is also responsible for the manner in which Area Agencies on Aging disseminate information and perform Waiver enrollment assistance functions.

The Division of Medical Assistance and Health Services is responsible for assessing the information dissemination and Waiver enrollment assistance functions performed by County Welfare Agencies (CWA).

Appendix A: Waiver Administration and Operation

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

The State Contract Manager, the Purchase Bureau, Division of Purchase and Property in the Department of Treasury, is the entity responsible to assess the performance of the DACS contracted Financial Management Services (FMS) on a monthly basis. Evaluation and monitoring of contracts happens within a number of contexts. The contract requires that the Financial Management Services develop a report that details the outcomes of the performance measurements, for submission to the State Contract Manager, on a monthly basis. The report includes a narrative explanation of the analysis, findings, trends, corrective actions taken and outcome measures taken regarding claims during the previous month. The Financial Management Services also generates exception reports on any of the operations required under the contract as requested by the State Contract Manager. The reports are available to Medicaid. While the primary responsibility to oversee a contract falls to the State Contract Manager, the Contract Compliance and Audit Unit (CCAU) within the Division of Purchase and Property may enter the scene when the State Contract Manager initiates a PB-36 Formal Complaint Filing. To date, the Contract Compliance and Audit Unit has never filed a Formal Complaint. The Supervisor of the Data Management Unit also has access to the monthly reports and reviews them for information and evidence of compliance with the contract.

The Financial Management Services, under contracted by the State, has the following duties and obligations: a) perform quality assurance activities; b) Interface with the Division of Aging and Community Services (DACs) Database server via internet; c) process claims for services and issue payments to health and social services providers; d) serve as the Employer Appointed Agency for Participant Provider; e) provide comprehensive payroll services for a segment of Home and Community Based Services participants who assure the role of employer and for their respective employees; and f) adjust previously paid claims as necessary. The Financial Management Services bills Medicaid for reimbursement of certain costs. The Fiscal Intermediary has developed performance measures for the accuracy and timeliness of the tasks including: submission of bills and invoices, payments to providers, payment of wages to Participant-Employed Providers (Participant-Employed Providers) length of processing times, record keeping, updating of manuals and instructions, training in response to requests and changes in regulations, resolution of claim discrepancies, and resolution of conflicts between participant/employers and Participant-Employed Providers. Please see Appendix A: 3 for additional responsibilities of the Financial Management Services.

All entities providing Care Management for the GO Waiver as operated by the Division of Aging and Community Services have a contract with the Division for care management and are enrolled as Medicaid providers to bill for the same. The Care Management entities include: Area Agencies on Aging, County Welfare Agencies, Licensed Certified Home Health Agencies, Accredited Registered Homemaker Agencies, Adult Family Care Sponsor Agencies, and proprietary or Not-for-Profit Care Management Entities. The Division of Aging and Community Services Quality Assurance Unit (QAU) conducts performance surveys of all Care Management entities responsible for participant re-evaluations and service plan approvals at least every 24 months. The QAU surveys are typically completed by a team of three to four County Liaison/Quality Assurance Specialists and include: a brief Entrance Interview with appropriate care management agency staff to explain the general format of the survey, in-home participant interviews as available, review of files that have been opened within the past three years, as well as review of participant files including when possible, a case utilizing a Participant-Employed Provider and a case from each Care Manager.

At the completion of the visit, the team meets privately to discuss the visit, identifying its concerns or areas to be addressed. A formal Exit Interview is then held for the agency's administrative Staff to summarize the overall findings. A Summary Report / Follow-up letter is sent to the agency within 30 business days of the on-site visit to outline the findings of the quality assurance survey. If a Remediation and Improvement Plan is warranted, the agency has 30 days from the date of the letter to respond. Once the Remediation and Improvement Plan is received, the County Liaison/Quality Assurance Specialist reviews it. If the Remediation and Improvement Plan is complete, an acceptance letter is drafted for the signature of the Quality Assurance Unit Supervisor advising the Care Management agency that the Plan is approved. If the Plan is insufficient, a response is generated, or a contact is made by the County Liaison/Quality Assurance Specialist to request additional information from the agency. When warranted, an additional on-site visit will be made by at least one County Liaison/Quality Assurance Specialist to assess the progress that has been made in the cited areas of deficiency. A copy of the Plan is sent to the Quality Management Unit in Medicaid. The QAU surveys may also consist of a review of continual quality improvement audits, with corresponding corrective actions, as performed by the Supervisory staff at the care management agencies. The same participant file review tool is used when auditing care management performance.

The Division of Medical Assistance and Health Services (Medicaid) conducts eligibility reviews for Title 19 and Title 21 programs in accordance with 42 CFR Part 431 (Medicaid Eligibility Quality Control (MEQC) and part 457 (Payment Error Rate Measurement (PERM)).

Active/Closed cases are randomly sampled from the County Welfare Agencies, statewide vendor, and reviewed against the State Plan for the purpose of identifying issues, developing and implementing corrective actions.

The Division of Aging and Community Services is responsible to assure that all non-traditional providers of Waiver

services meet all criteria initially and an ongoing basis to provide the service(s) for which they have been approved.

Appendix A: Waiver Administration and Operation

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

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Level of care evaluation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

The DMAHS' QMU utilizes a comprehensive audit to assess: timeliness of access to service and compliance with all waiver assurances. This is done with a required corrective action plan from DACS for less than 90% compliance with each of the waiver subassurances. Numerator:#of deficient participant records for each subassurance;Denominator:#of participant records reviewed for each subassurance.

Data Source (Select one):

Other

If 'Other' is selected, specify:

QMU Workplan; Annual Comprehensive Audits; Targeted Interim Audits; QI Topic Audits; DMAHS working files; State Operating Agency policies and procedures; and Interdepartmental resources.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% with an error rate of 5% and a response distribution of 50%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

<input checked="" type="checkbox"/> Other Specify: Quality Management Unit within the State Medicaid Agency, the Division of Medical Assistance and Health Services (DMAHS/QMU)	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

The DMAHS/QMU Team meets on a quarterly basis and retains meeting minutes on file. A designated Clinical Lead Liaison from this Team, is assigned to the State Operating Agency, DACS to coordinate and oversee the development and finalization of the Waiver audit process and reports findings directly to the QMU Administrator. The QMU Liaison attends the DACS Quality Assurance Unit staff meetings on a quarterly basis and conveys information back to the QMU Team at the quarterly Quality Assurance Advisory Committee meetings. Initiatives completed to date include: Quality Management Unit Work Plan that facilitates an organized and effective implementation of Medicaid Single State Agency Administrative Oversight to each of the State Operating Agency's Quality Management Strategies. Work Plan components include: Oversight Management, Quality Assurance and Quality Improvement Monitoring and Coordination of Interdepartmental Resources (Surveillance Utilization Review Subsystem, State Fiscal Agent, Office of Licensing), and the Development of the Quality Management Unit Policy and Procedure Manual for implementation of the Work Plan and the QMU Resource Library.

The QMU oversight and monitoring responsibilities encompass scheduled Annual Comprehensive Audits, Interim Targeted Audits, to track continued compliance to Plans of Corrections, and collection and analysis of aggregate data to monitor trends for development of system-wide quality improvement Topic Audit(s). The focus of the Topic Audits will be determined annually. Comprehensive and Interim Targeted Audits will include a review of the level of care (LOC) determinations and LOC reevaluations for accuracy, the responsiveness of POC to participant needs identified in the evaluations and reevaluations, the assurance that individuals receive services from qualified providers, that the health and welfare of waiver participants is addressed, and financial accountability is assured for the services rendered. Follow-up measures for remediation are initiated by the QMU as needed.

A copy of the Survey Report/Follow-Up Letter after DACS conducts a survey of care management agencies as well as a copy of any subsequent Remediation and Improvement Plan submitted by the Care Management Agency are sent to the Quality Management Unit in Medicaid for their records.

The QMU also reviews periodic DACS Reports of aggregated data from internal audits/quality assurance reviews to ensure compliance with Waiver assurances.

b. Methods for Remediation/Fixing Individual Problems

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

The DMAHS/QMU uses its own comprehensive audit tool during the annual comprehensive audits. A corrective action plan is required from the State Operating Agency, DACS, when there is greater than 10% of the files audited lacking the necessary documentation to meet the related waiver assurance. In instances that may have the potential for adversely affecting the health and well-being of participants, functioning of staff, or potentially impacting upon fiscal responsibility, the Quality Management Unit's Clinical Liaison notifies the QMU Healthcare Administrator who confers with DMAHS Medical Director for follow-up measures to include notification to the DACS Quality Assurance staff and the Director of the DACS Office of the Assistant Commissioner.

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
	<input checked="" type="checkbox"/>	Aged	65		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	21	64	
	<input type="checkbox"/>	Disabled (Other)			
Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>

	<input type="checkbox"/>	Technology Dependent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Retardation or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness					
	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Serious Emotional Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

An applicant under 65 shall be determined disabled by the Social Security Administration (SSA) or be determined disabled by the Division of Medical Assistance and Health Services, Disability Review Section. Individuals between the ages of 21 and 64 who are chronically mentally ill, mentally retarded (intellectually disabled) or developmentally disabled are ineligible for Global Options for Long-Term Care enrollment.

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

Not applicable. There is no maximum age limit

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

Specify:

Not applicable. There is no maximum age limit because those individuals determined physically disabled between the ages of 21-64 may remain on the waiver when they reach the age of 65 as long as they meet all applicable waiver eligibility criteria for continued enrollment.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

[Empty text box]

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

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

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

[Empty text box]

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

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

[Empty text box]

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

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

Specify percent:

Other:

Specify:

[Empty text box]

Appendix B: Participant Access and Eligibility

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

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

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

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

- The participant is referred to another waiver that can accommodate the individual's needs.**
- Additional services in excess of the individual cost limit may be authorized.**

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

- Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	13438
Year 2	14110
Year 3	14816
Year 4	15557
Year 5	16335

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

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

Not applicable. The state does not reserve capacity.

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

Appendix B: Participant Access and Eligibility

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

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

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

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

- e. **Allocation of Waiver Capacity.**

Select one:

Waiver capacity is allocated/managed on a statewide basis.

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

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

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

The selection of individuals for entrance to the GO Waiver is facilitated regionally. Once a comprehensive evaluation is executed, options counseling is performed, and only after all other GO eligibility criteria are met by the applicant shall enrollment occur.

Individuals who seek Global Options enrollment instead of nursing facility institutionalization, and who: meet the clinical and financial eligibility criteria, are part of the target population, and who require the receipt of at least two GO waiver services (one of which is care management), will be considered for Global Options for Long-Term Care enrollment.

Regardless of the No Cost Limit option selected as applied when determining entrance to the GO Waiver, it is not expected that an individual will be offered enrollment onto the GO Waiver unless the comprehensive evaluation indicates that the person's needs (including assuring the persons' health and welfare) can be met through the provision of Waiver services in combination with State plan services, other formal and informal supports, and appropriate safeguards.

Enrollment onto the GO Waiver is defined as the result of implementing all processes that must be completed in order for an individual to begin to receive GO waiver services.

In order for an individual to participate in the GO Waiver:

- (a) the applicant must have been determined to meet applicable NJ State Medicaid eligibility criteria;
- (b) there must have been a determination that the applicant is a member of the target population which is included in the GO waiver;
- (c) there must have been a determination that the applicant requires the clinical nursing facility level of care specified in the GO waiver;
- (d) the applicant must have exercised freedom of choice and has elected to receive the GO waiver instead of institutional services; and,
- (e) a service plan (interim Plan of Care) must have been developed that includes the need for GO waiver services.

In addition, GO enrollment can not occur:

- If the applicant is enrolled in any other HCBS Medicaid Waiver or in the State's Program of All Inclusive Care for the Elderly (PACE).
- If the applicant is a current beneficiary of the State's Medicaid Hospice State Plan service or the Medicare Hospice benefit.
- If the applicant qualifies as a Medicaid Medically Needy beneficiary.
- If the applicant is seeking enrollment solely to gain access to the Medicaid State Plan benefit.

If the GO applicant is a resident of a nursing facility, it is strongly advised that an Interdisciplinary Team meeting(s) occur to discuss the sometimes complex facets of institutional transitions and to consider implementing the Money Follows the Person initiative to facilitate the transition, as appropriate.

Federal Financial Participation (FFP) is not available for the costs of services furnished to an individual prior to enrollment.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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

§1634 State

SSI Criteria State

209(b) State

2. **Miller Trust State.**

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

No

Yes

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

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

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

Select one:

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

Specify percentage:

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

Specify:

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

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:**

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- Aged and disabled individuals who have income at:**

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

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

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

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

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

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

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

The following standard included under the State plan

Select one:

SSI standard

Optional State supplement standard

Medically needy income standard

The special income level for institutionalized persons

(*select one*):

300% of the SSI Federal Benefit Rate (FBR)

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

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the State Plan

Specify:

[Empty text box]

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

[Empty text box]

Other

Specify:

Supplemental Security Income plus the optional State supplement for individuals who reside in Assisted Living and Adult Family Care. For all other individuals, 300% of the Federal Benefit Rate.

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

Not Applicable

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

Specify:

[Empty text box]

Specify the amount of the allowance (select one):

SSI standard

Optional State supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

[Empty text box]

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

The State does not establish reasonable limits.

The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

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

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

Appendix B: Participant Access and Eligibility

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional State supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

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

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

Supplemental Security Income plus the optional State supplement for individuals who reside in Assisted Living and Adult Family Care. For all other individuals, 300% of the Federal Benefit Rate.

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

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

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

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

expenses.

Select one:

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

The State does not establish reasonable limits.

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

- i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 2

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

- The provision of waiver services at least monthly**

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

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

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

- Directly by the Medicaid agency**

- By the operating agency specified in Appendix A**

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

Specify the entity:

Other

Specify:

Level of care evaluations are performed by the operating agency specified in Appendix A (the NJ Department of Health and Senior Services). Professional Staff designated by the Department of Health and Senior Services may perform Initial Evaluations and Re-evaluations. Re-evaluations are also completed by Medicaid approved Waiver Care Management Sites.

- c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the

educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

“Professional Staff designated by the Department” means a Registered Nurse or Professional Social Worker that performs the initial evaluation of level of care for Waiver applicants. Professional Social Workers employed by the State, or a political subdivision thereof, are not required to be licensed or certified. (NJAC 8:85-1.2 Definitions). If the Social Worker is not licensed or certified, he or she must meet the following qualifications: Education - Graduation from an accredited college or university with a Bachelor’s degree and Experience: One (1) year of experience working with the elderly or physically disabled in an institutional or community setting.

Applicants who do not possess the required education may substitute additional experience on a year-for-year basis with 30 semester hour credits being equal to one (1) year of experience.

Graduation from an accredited college or university with a Master’s degree with concentration in the field of social work, gerontology or social gerontology may be substituted for the experience.

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

Evaluation:

New Jersey has three Statewide State regional Offices of Community Choice Options. The primary function of these Offices is to employ Staff to pre-screen and provide options counseling to individuals seeking Medicaid coverage for long-term care services, in a nursing facility or in the community, determine clinical eligibility and prior authorize services. The Community Choice Counselors that perform the pre-admission screens are State employees who are Registered Nurses or Social Workers, who use the New Jersey Choice evaluation tool (standardized assessment and level of care instrument) to complete the clinical evaluation. An individual shall be clinically eligible for nursing facility level of care services when the individual’s standardized assessment results in an Activity of Daily Living (ADL) index score of six or greater, or a Cognitive Performance Scale (CPS) score of three or greater or requires a level of limited assistance or higher in all three of the following activities of daily living – bathing, dressing (upper or lower), and locomotion (indoors or outdoors).

ADL index means the RUG-III/HC case mix algorithms that include a summary measure of ADL that combines scores for, bed mobility, toileting, transferring and eating. Scores range from four (independent or supervision in all four areas) to 18 (severe impairment in all four areas). CPS means an assessment index with the MDS-HC used to assess individuals on the basis of memory impairment, level of consciousness, and executive function, with scores ranging from zero (intact) to six (very severe impairment).

This New Jersey Choice tool is the result of a three and a half year search for an evaluation tool that would capture the elements necessary to provide an accurate outcome to the evaluation and electronic data to collect, analyze and trend for quality improvement. The history of the development of the tool is as follows: In 2005 the Office of Community Choice Options (OCCO) began piloting a computerized pre-admission screening tool that is based upon the internationally validated InterRAI Minimum Data Set-Home Care (MDS-HC) clinical evaluation tool. The MDS-HC is defined to mean the assessment instrument developed and published by interRAI, incorporated as amended and supplemented, a core set of screening, clinical and functional status elements, including common definition and coding categories that forms the foundation of the assessment required to determined eligibility for nursing facility services pursuant to NJAC 8:85-2.1. In 2010 the NJChoice, comprehensive evaluation, was rolled out Statewide as the State’s pre-admission screening tool.

In 2005 the Aging and Disability Resource Center/Connection (ADRC) initiative began piloting a more comprehensive Minimum Data Set-Home Care evaluation tool known as MI-Choice (Michigan Choice). The tool offered several features that the Minimum Data Set-Home Care did not include. First, the additional data elements, which focus on the person’s social/supportive environment are critical for assessing individuals’ health and safety factors when considering alternative Long Term Care community settings. Second, NJ-Choice included an algorithm that will predict the care needs of persons seeking long-term care assistance. The algorithm predicts five “levels of care” needs, which are: nursing home, home care, intermittent personal care, homemaker, and information and referral. And third, the algorithm is imbedded in a telephone-screening instrument that enables information & referral specialists to target individuals at-risk-of nursing home placement and refer them to clinical assessors who can determine their level of care needs and counsel them on alternative home and community-based services.

Based upon the piloting of the evaluation tools, the MI-Choice (renamed New Jersey Choice) was selected as the pre-admission screening tool. Through a professional services contract, the University of Michigan, the national

repository for State-level Minimum Data Set-Home Care data, was hired to analyze New Jersey's pre-admission screenings and establish a validated level of care that met State regulations. To achieve this goal, the University of Michigan accomplished the following activities:

- (1) Completed an analysis of New Jersey's State Fiscal Year 2007 pre-admission screening evaluations and recommended a clinical nursing facility level of care algorithm to support the State's NJAC 8:85 regulations;
- (2) Based upon the analysis, reformulated the current New Jersey Choice pre-admission screening algorithm to comply with the State's nursing facility level of care. The nursing facility level of care algorithm has been programmed into the Division's New Jersey Choice database to automate and maintain a decision support system for determining nursing facility level of care. The Division of Aging and Community Services completed and implemented this Statewide in August 2010.
- (3) Based upon the analysis, finalized the telephone screening tool. The telephone screening tool is used to identify individuals at risk of nursing home placement and who should be referred for comprehensive pre-admission screenings.

Copies of State laws, regulations and policies concerning level of care criteria and the level of care instrument/tool are available to CMS from the NJDHSS Division of Aging and Community Services upon request.

Re-evaluation:

The criteria for level of care during the re-evaluation process is the same as for the initial level of care evaluation. An individual shall be re-evaluated as clinically eligible for nursing facility level of care services when the individual's re-evaluation results in an Activity of Daily Living (ADL) index score of six or greater, or a Cognitive Performance Scale (CPS) score of three or greater or requires a level of limited assistance or higher in all three of the following activities of daily living – bathing, dressing (upper or lower), and locomotion (indoors or outdoors).

Re-evaluations are completed by the participant's Care Manager using a form, WPA-1, that is based upon the New Jersey-Choice / comprehensive evaluation tool. A re-evaluation must be completed annually. GO Medicaid Waiver participants that are re-evaluated as not meeting nursing facility level of care are referred to the Office of Community Choice Options for an evaluation. The Office of Community Choice Options' eligibility determination is final. If the Office of Community Choice Options agrees that individual no longer meets level of care, the individual is assisted to find alternative services; if the individual disagrees with the Office of Community Choice Options' determination, he or she may file for a Fair Hearing and services continue until the Hearing is held and a final decision is rendered.

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

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

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

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

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

Professional Staff, designated by the Department, completes the initial evaluation to determine nursing facility level of care for Waiver applicants using the Department approved clinical evaluation tool. The comprehensive evaluation tool that serves as the standardized assessment is the Minimum Data Set Home Care (MDS-HC)/NJChoice. Determination of level of care is based on criteria as indicated in NJAC 8:85-2.1. An individual shall be clinically eligible for nursing facility level of care services when the individual's standardized assessment results in an Activity of Daily Living (ADL) index score of six or greater, or a Cognitive Performance Scale (CPS) score of three or greater or requires a level of limited assistance or higher in all three of the following activities of daily living – bathing, dressing (upper or lower), and locomotion (indoors or outdoors).

Re-evaluations are completed during a face-to-face interview by the Waiver Care Manager or other professional Staff designated by the Department. The deficits that determine NF Level of Care are summarized and evaluated using either the Long Term Care Re-Evaluation Form (WPA-1) or the NJChoice/Comprehensive evaluation tool. The

evaluation of level of care is based on criteria as indicated above -- a GO participant shall be clinically eligible for nursing facility level of care services when the individual's re-evaluation results in an Activity of Daily Living (ADL) index score of six or greater, or a Cognitive Performance Scale (CPS) score of three or greater or requires a level of limited assistance or higher in all three of the following activities of daily living – bathing, dressing (upper or lower), and locomotion (indoors or outdoors). The social support network and physical environment are also summarized on the Re-evaluation (WPA-1) form.

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

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

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

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

The qualifications are different.

Specify the qualifications:

Care Managers or other Professional Staff designated by the Department complete re-evaluations. Those completing re-evaluations must be licensed, Registered Nurses, NJSA 45:11-26; OR licensed or certified Social Workers, NJSA 45: 1-15; OR have graduated from an accredited college or university with a Bachelor's degree, or higher, in a health related or behavioral science field and have had the following experience: 1,600 hours (46 weeks working 35 hours per week) of paid work or internship experience (non-volunteer) with the elderly or physically disabled in an institutional or community setting.

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

A participant's level of care re-evaluation is a component part of Care Management and is completed on-site face-to-face with the participant within one year of the date of the last evaluation (initial evaluation or re-evaluation) or more frequently if there is a change in the participant's needs. To ensure timely re-evaluations, the Care Manager indicates the re-evaluation due date in a date field on the Long-Term Care Re-evaluation Form WPA-1. The importance of timely evaluations is emphasized in Care Management trainings. At the time of the State's Quality Assurance Survey, files are reviewed on-site for the timeliness of the re-evaluations.

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

Copies of the initial level of care evaluation are stored on a central server that is supported and maintained by State Medicaid Information System professionals. Data is electronically entered onto a Minimum Data Set-Home Care database via remote computer access during the client evaluation and then the comprehensive evaluation and interim plan of care are uploaded to a central server that is supported and maintained by State Medicaid Information System professionals. The data is stored indefinitely on a Structured Query Language (SQL) 2005 database that resides on a Dell 6850 server running Microsoft Server 2003. The data is stored in 1 database object and is comprised of 11 functional tables and several support and system tables. The data object is backed up several times a day using the built-in SQL backup tool that comes native to all SQL servers. Once a week the entire server and all files are backed up to tape. Incremental backups are done daily.

The Care Management Site keeps a paper copy of the Initial Comprehensive Evaluation as well as successive Long-Term Care Re-evaluations in the participant's file on-site.

All participant records, including the initial evaluation and re-evaluation documents, are kept at the Care Management site for 5 years following the termination or transfer of a participant.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

i. Sub-Assurances:

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Number and percent of all new enrollees who have an evaluation for level of care provided considering all applicants for whom there is reasonable indication that services may be needed in the future.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = OCCO RQM uses: Confidence Interval of 4; Confidence Level Needed equals 95%, the population size is that of the GO Medicaid Waiver applicants; the

		Response Distribution equals 50%
<input type="checkbox"/> Other Specify: _____	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of Initial LOC approvals are evaluated by each OCCO Regional Office for quality each month and are subsequently submitted to the OCCO RQM on a quarterly basis.
	<input type="checkbox"/> Other Specify: _____	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: _____	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: _____

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Number and percent of GO participants whose level of care is reevaluated at least annually.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Record reviews, off-site

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Care Management Supervisors are responsible for reviewing 100 percent of all LOC reevaluations completed by the Care Managers.	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from each Care Manager, opened during past 3 years, calculating sample size with Conf Intvl of 5; Confidence Level of 95%; Pop Size:# of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify:

		A random sample of LOC reevaluations are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

Performance Measure:

The number and percent of records reviewed demonstrate that the process and instruments described in the approved waiver are applied to determine the reevaluations of level of care.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DHSS' DACS has developed a method to track and analyze the number of times, circumstances and outcomes of 'Care Manager Request for Reassessment' (CM-RR) to OCCO.

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

		Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

The number and percent of records reviewed demonstrate that the process and instruments described in the approved waiver are applied to determine the initial evaluations of level of care.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = OCCO RQM uses: Confidence Interval of 4; Confidence Level Needed equals 95%, the population size is that of the GO Medicaid Waiver applicants; the Response Distribution equals 50%
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of Initial LOC approvals are evaluated by each OCCO Regional Office for quality each month and are subsequently submitted to the OCCO

		RQM on a quarterly basis.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

The number of records reviewed demonstrate that the process and instruments described in the approved waiver are applied to determine the reevaluations of level of care.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Record reviews, off-site

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

<input checked="" type="checkbox"/> Other Specify: Care Management Supervisors are responsible for reviewing 100 percent of all LOC reevaluations completed by the Care Managers.	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from each Care Manager, opened during past 3 years, calculating sample size with Conf Intvl of 5; Confidence Level of 95%; Pop Size:# of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of LOC reevaluations are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

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

responsible.

New Jersey has three Statewide Regional Offices of Community Choice Options (OCCO). The primary function of these Offices is to employ Staff to pre-screen individuals seeking Medicaid for long-term care services, in a nursing facility or in the community, determine clinical eligibility and prior authorize services. The Community Choice Counselors (CCCs) that perform the pre-admission screens are State employees who are Registered Nurses or Social Workers, who use the NJChoice/Comprehensive Evaluation tool to complete the clinical evaluation.

The Division of Aging and Community Services (DACS), Regional Offices of Community Choice Options (OCCO), and professional staff designated by the Department of Health and Senior Services conduct Level of Care (LOC) assessments for 100 percent of applicants for whom there is reasonable indication that services may be needed in the future.

On a quarterly basis, the OCCO Regional Field Office Managers (FOMs) send statistical reports to the OCCO Regional Quality Manager (RQM) for review. The OCCO RQM analyzes the data to monitor outcomes and assess for trends. Since January 2006, OCCO has completed reports that analyze OCCO's LOC Audit outcomes. A random sample of Initial LOC approvals are evaluated by each OCCO Regional Office for quality each month and are subsequently submitted to the OCCO RQM on a quarterly basis.

OCCO uses the CMS referred 'Sample Size Calculator' to compute the sample size by using the following parameters: Confidence Interval (margin of error accepted) equals 4; the Confidence Level Needed equals 95%, the population size is that of the GO Medicaid Waiver applicants; the Response Distribution equals 50%

The OCCO FOMs and/or Assistant FOMs are primarily responsible for conducting the audits for the initial LOC approvals. The OCCO RQM periodically assists with these reviews. If or when more detailed information is needed on Activities of Daily Living and Instrumental Activities of Daily Living, cognitive impairment levels, etc. it is available through the assessment database. Any areas identified as requiring remediation are discussed by the FOM/AFOM and CCC, and are resolved accordingly with FOM and/or AFOM oversight. The final outcome of each area of remediation is recorded by the FOM or AFOM on the audit tool. The FOM/AFOM keeps an original copy of each case audit for future review. These audit records are stored onsite at each respective OCCO Regional Field Office for a period of three years then are subsequently archived to DHSS records storage facilities per State record storage and retention protocols. There is a standardized audit form used by all reviewers statewide to record the outcome of each case audit. The results of each audit are registered on a worksheet that is submitted to the OCCO RQM in Central Office.

On a quarterly basis, the OCCO RQM compiles this information statewide, and then analyzes and reports data outcomes and trends to OCCO and GQ. As deficiencies and areas for improvement are identified, staff training that focuses on deficient areas is arranged.

One hundred percent of all denials for initial LOC determinations are reviewed. OCCO staff is required to contact his or her supervisor to review the assessed care needs of the applicant before making the determination to deny the case. If the OCCO FOM or AFOM thinks that the LOC determination may be inappropriate, a second LOC evaluation is conducted by a different CCC to either validate the first CCC's initial LOC denial or to support the perception by the FOM/AFOM that the participant met LOC. Based upon the outcome of this second LOC evaluation, the applicant is either approved or denied. If LOC is approved, then the CCC issues an approval letter. If LOC is denied, then the CCC issues a denial letter to the applicant that contains Fair Hearing information/instructions.

There are no formalized after-the-fact reviews of denials since the circumstances of every denial are discussed with the FOM/and Assistant Field Office Manager (AFOM) before the denial outcome is communicated to the applicant.

The Central Office OCCO RQM oversees the monitoring functions of the OCCO FOMs/AFOMs in the three Statewide Regional Offices. The FOMs and AFOMs, in turn, supervise the front-line clinical performance of their CCCs. It is ultimately the responsibility of the FOMs/AFOMs to monitor that staff complies with the denial case conferencing rule. The CCCs record all cases and outcomes on a daily log that is turned in to their supervisor at the end of each month, thus enabling the FOMs/AFOMs to verify all denials that were case conferenced that month. The OCCO RQM reviews the reports and creates a quarterly statistical report of the outcome of PAS Assessments.

In August 2006 Deficiency Ratings and Documentation Guidelines were developed and distributed to OCCO staff to assist in the completion of record auditing by the FOMs/AFOMs. In December 2007, the Office of Community Choice Options disseminated a formal Remediation Plan to ensure compliance with CMS level of care assurances, and the two-page audit tool to standardize this process was updated in January 2008. In summary, OCCO FOMs/AFOMs have specific auditing and reporting procedures and timeframes, that have been in place and refined since 2006, to remain compliant with quality oversight activities. Individual staff counseling as well as quarterly regional staff meetings are also conducted by the FOM/AFOMs to assist in continual quality improvement for OCCO operations. Finally, changes were made to OCCO's internal control process for record storage to ensure that records can be easily retrieved. The newly revised process, entitled "The Quality Audit Process" now includes guidance to field office staff on maintaining audit files and was reviewed with FOM and AFOMs in July 2010. Care Managers (CM) are responsible to reevaluate continued eligibility.

b. Methods for Remediation/Fixing Individual Problems

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

The reevaluation is completed at least annually or more frequently if there is a change in the participant's condition or informal supports. If the participant does not appear to meet LOC criteria, the Care Manager (CM) consults with the CM Supervisor. If both agree with the reevaluation, the CM asks the participant to voluntarily withdraw from the Waiver and offers other appropriate referrals to non-waiver services/programs. If the person does not agree to voluntarily withdraw, the CM, in consultation with the CM Supervisor, requests that OCCO reassess the participant. OCCO has developed a method to track and analyze the number of times, circumstances and outcomes of such requests which are now formalized through a Care Manager Request for Reassessment (CM-RR) standard currently implemented statewide. When requested by the CM agency, the CCC will perform a comprehensive LOC reevaluation and if he or she agrees that the participant no longer meets LOC, the case is reviewed with the FOM/AFOM. If both agree that the participant does not meet LOC, a denial is issued to the participant. The individual is notified of his or her right to a Fair Hearing and services continue until the appeal verdict is rendered. The Office of Community Choice Options (OCCO) started tracking Care Manager Request for Reassessments (CM-RR) at the end of December 2007. Care Manager Requests for Reassessments during 2008 indicate that a total of 56 CM-RRs were made by Care Managers. Three of those requests, or 5%, resulted in participants being determined clinically ineligible for continued enrollment in the program; 41 (73%) of the requests determined that the participants remained clinically eligible for the program; 3 (5%) of the requests were withdrawn by the Care Manager; and 9 (16%) of the requests ended with the participant choosing to voluntarily withdraw from the program. Based on the overall analysis of the 2008 CM-RR report, DACS made several discoveries on CM-RR and Level of Care reevaluation operational procedures. As a result, training was provided by DACS staff on the Level of Care reevaluation process at regional Care Management meetings and Care Coordinators/Care Management Supervisors meetings, an on-site at specific care management sites. During the QAU reviews, among other aspects of the program, DACS County Liaisons/Quality Assurance Specialists examine whether the LOC Reevaluation was completed in a timely fashion and if the Care Management Supervisor reviewed and signed the Long Term Care Re-evaluation (WPA-1) documentation. Care Management Supervisors are responsible for reviewing 100 percent of all LOC reevaluations completed by the Care Managers. DACS surveyors review a stratified sample of GO Medicaid Waiver program participant files to ensure among other standards that files have a current LOC Re-evaluation (WPA-1), that LOC Re-evaluations are completed annually, that the LOC Reevaluations that are present have adequate written justification/documentation of the level of care criteria and that LOC Reevaluations have the signature of the Care manager and Care Management Supervisor. The (MDS-HC)NJ Choice/Comprehensive evaluation tool, as identified and included in the 2011 GO Waiver renewal application, is used exclusively to determine Initial Level of Care assessments. As stated earlier, OCCO has assembled a team, headed by the Regional Quality Manager (RQM) to review LOC approvals and the correct use of the NJChoice tool and the adequacy of the subsequent Interim Plan of Care. The OCCO Field Office Managers and Assistant Field Office Managers review a random sample of level of care determinations to ensure that the participants were afforded choice, the nursing facility level of care authorization was appropriate, and the LOC determinations were made in a timely manner. Re-evaluations of Level of Care are completed by the GO participant's Care Manager using a form, (WPA-1), which is based upon the NJChoice evaluation tool. A re-evaluation of level of care must be completed as needed, at least annually, for all GO Waiver participants. DACS has steadily made improvements on the area of ensuring that level of care reevaluations are executed appropriately and using the specified tools. For many years, the WPA-2 form combined both the Plan of Care and the Reevaluation of LOC onto one document. It was determined that there was a viable need to separate it into two separate forms: one for the Plan of Care and the other for the Reevaluation of Level of Care, specifically to re-emphasize the distinction between the two related processes. An MDS-HC guide was distributed in September 2006 to all Care Management agencies

for help in more accurately completing the Plans of Care (WPA-2 forms). In September 2007, a formal independent Reevaluation of Level of Care policy, form, and instructions were completed and disseminated to all Care Managers. The new LOC Reevaluation form became known as the WPA-1 and has since been used to complete Reevaluations for GO Waiver participants. The Plan of Care remains known as the WPA-2 form. The Long Term Care Reevaluation policy, WPA-1 form, and instructions were revised for clarification purposes in June 2011 to be redistributed to all Care Managers. During survey reviews, the DACS Quality Assurance Unit's County Liaisons/QA Specialists verify that the appropriate tool (i.e the WPA-1) is being used to conduct Level of Care Reevaluations. DACS surveyors review a stratified sample of GO Medicaid Waiver program participant files to ensure among other standards that not only is the LOC reevaluations completed on the approved tool, but also that the LOC reevaluations were determined by the Care Manager as opposed to someone else; and there was evidence that the reevaluations were being executed annually or as necessary based on a change in the participants needs.

ii. **Remediation Data Aggregation**

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHSS/OCCO; DACs Quality Assurance Unit;	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

c. **Timelines**

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

No

Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Before enrollment into the GO Waiver, Professional Staff designated by the Department reviews and discusses the

Choice of Care form (CP-6) with the applicant and/or legal representative. The applicant and/or legal representative's signature on the form verifies that Waiver service alternatives and institutionalization have been discussed with the applicant and/or legal representative and that he or she has chosen home and community-based services. Copies of the Choice of Care form are available upon request.

Options counseling, for potentially eligible individuals, at the County level is offered through the Aging and Disability Resource Connection network which provides intake, screening and referral services. ADRC sites provide a consumer-friendly way for seniors and their families to get information about and access senior services. The former NJ Easy Access Single Entry (NJEASE) system was enhanced through a statewide roll-out to phase in implementation of the Administration on Aging/Centers for Medicare and Medicaid Services 'Aging and Disability Resource Center' (ADRC) initiative.

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

Copies of the GO Waiver participant's Choice of Care Form (CP-6) are on file in the Department of Health and Senior Services case record that is stored at the Department of Health and Senior Services, Office of Community Choice Options servicing the Waiver participant's region. The participant's case record is stored at the regional field office for the entire length of active Waiver service and is archived when Waiver services are terminated. Terminated Waiver case records are maintained for a minimum of three years.

A copy of the Choice of Care Form CP-6 is also kept on file at the Care Management site for 5 years following the termination or transfer of a participant.

Appendix B: Participant Access and Eligibility

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

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

- The Department assists persons with limited English proficiency through the use of AT&T Language Line services that includes over-the-phone interpretation for 150 languages. In addition, the Department and relevant county offices have Staff that assists with bilingual interpretation. Key forms and letters used by consumers are also available in Spanish.
- Each county Area Agency on Aging must provide in its "Area Plan Contract" (Older American's Act) with the State assurances that the county will conduct efforts to reach older individuals with limited English-speaking ability.
- All county Area Agencies on Aging use AT&T Language Line assistance for the translations of 150 languages.
- The County Welfare Agencies usually have Staff that can speak the necessary languages. If they do not have a person present and the applicant does not bring someone to act as an interpreter, they use AT&T Language Line assistance.
- The Division of Aging and Community Services (DACs) is developing a Cultural Competency Model that will address issues of access, cultural competence, and linguistic competence and will contain specific indicators with related outcomes. This will be tested in the Division of Aging and Community Services and two Aging & Disability Resource Center/Connection (ADRC) counties.
- The Division of Aging and Community Services has an Information and Assistance hotline that uses the AT&T Language Line assistance.

On an ongoing basis, oral and written assistance to participants with limited English proficiency takes various forms, including hiring bilingual care management staff or aides, arranging for interpreters, and translating written materials when a significant amount of program participants require information in a language other than English.

Appendix C: Participant Services

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

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

Service Type	Service		

Statutory Service	Care Management
Statutory Service	Respite
Other Service	Adult Family Care
Other Service	Assisted Living (ALR or CPCH)
Other Service	Assisted Living Program (ALP) in Subsidized Housing
Other Service	Attendant Care
Other Service	Caregiver Participant Training
Other Service	Chore Services
Other Service	Community Transition Services
Other Service	Environmental Accessibility Adaptations (EAA)
Other Service	Home-Based Supportive Care
Other Service	Home-Delivered Meals
Other Service	Personal Emergency Response System (PERS)
Other Service	Social Adult Day Care
Other Service	Specialized Medical Equipment and Supplies
Other Service	Transitional Care Management
Other Service	Transportation

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Care Management

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Care Management is a service that will assist individuals who receive Waiver services in gaining access to needed Waiver and other State Plan services (as identified in the Waiver), as well as medical, social, educational and other services, regardless of the funding source.

Care Managers are responsible for ongoing monitoring of the provision of services included in the individual's Plan of Care.

Care Managers initiate and oversee the process of re-evaluation of the individual's level of care and the review of plans of care every 12 months at a minimum.

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

Care Managers are required to contact each participant at specific intervals, on an as needed basis, and visit each participant quarterly. Examples of circumstances that would be considered an "as needed basis" contact by the Care Manager could include: if the participant requested a change in service provider or frequency of services, if the participant prompted a contact to the Care Manager, if the participant had a recent hospitalization, or if the participant needed assistance of some sort and a change in the Plan of Care were necessary.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Family Care Sponsor Agency
Agency	Accredited Registered Homemaker Agency
Agency	Licensed Medicare Certified Home Health Agency
Agency	Proprietary or Not-for-Profit Care Management Entity
Agency	Area Agency on Aging
Agency	County Welfare Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Care Management

Provider Category:

Agency

Provider Type:

Adult Family Care Sponsor Agency

Provider Qualifications

License (specify):

Licensed per NJSA 26:2Y

Certificate (specify):

N/A

Other Standard (specify):

Care Managers or other Professional Staff designated by the Department complete re-evaluations. Those completing re-evaluations must be licensed, Registered Nurses, NJSA 45:11-26; OR licensed or certified Social Workers, NJSA 45: 1-15; OR have graduated from an accredited college or university with a Bachelor's degree, or higher, in a health related or behavioral science field and have had the following experience: 1,600 hours (46 weeks working 35 hours per week) of paid work or internship experience (non-volunteer) with the elderly or physically disabled in an institutional or community setting.

Agency must be Medicaid approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Community Services

Frequency of Verification:

Every two years

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Care Management

Provider Category:

Agency

Provider Type:

Accredited Registered Homemaker Agency

Provider Qualifications**License (specify):**

NJAC 13:45B-14 (Division of Consumer Affairs)

Certificate (specify):

Commission on Accreditation for Home Care Inc. or National Association for Home Care and Hospice or Community Health Accreditation Program or the Joint Commission on Accreditation of Healthcare Organizations.

Other Standard (specify):

Agency employees must be licensed, Registered Nurses, NJSA 45:11-26 OR licensed or certified Social Workers, NJSA 45:1-15.

Agency must be Medicaid approved.

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

Accrediting Body

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service**Service Name: Care Management**

Provider Category:

Agency

Provider Type:

Licensed Medicare Certified Home Health Agency

Provider Qualifications**License (specify):**

NJAC 8:42

Certificate (specify):

CMS

Other Standard (specify):

Agency employees must be licensed, Registered Nurses, NJSA 45:11-26 OR licensed or certified Social Workers, NJSA 45:1-15.

Agency must be Medicaid approved

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

Department of Health and Senior Services

Division of Aging and Community Services

Frequency of Verification:

Every two years

Every two years

Appendix C: Participant Services

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

Service Type: Statutory Service**Service Name: Care Management**

Provider Category:

Agency

Provider Type:

Proprietary or Not-for-Profit Care Management Entity

Provider Qualifications**License (specify):**

NJSA 45:11-26

NJSA 45: 1-15

Certificate (specify):

N/A

Other Standard (specify):

Medicaid approved

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

Division of Aging and Community Services

Frequency of Verification:

Every two years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Care Management****Provider Category:**

Agency

Provider Type:

Area Agency on Aging

Provider Qualifications**License (specify):**

45Code of Federal Regulations 132.1

Certificate (specify):

N/A

Other Standard (specify):

Care Managers or other Professional Staff designated by the Department complete re-evaluations. Those completing re-evaluations must be licensed, Registered Nurses, NJSA 45:11-26; OR licensed or certified Social Workers, NJSA 45: 1-15; OR have graduated from an accredited college or university with a Bachelor's degree, or higher, in a health related or behavioral science field and have had the following experience: 1,600 hours (46 weeks working 35 hours per week) of paid work or internship experience (non-volunteer) with the elderly or physically disabled in an institutional or community setting.

Agency must be Medicaid approved.

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

Division of Aging and Community Services

Frequency of Verification:

Annually

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Care Management****Provider Category:**

Agency

Provider Type:

County Welfare Agency

Provider Qualifications**License (specify):**

NJAC 10:60-10

Certificate (specify):

N/A

Other Standard (specify):

Care Managers or other Professional Staff designated by the Department complete re-evaluations. Those completing re-evaluations must be licensed, Registered Nurses, NJSA 45:11-26; OR licensed or certified Social Workers, NJSA 45: 1-15; OR have graduated from an accredited college or university with a Bachelor's degree, or higher, in a health related or behavioral science field and have had the following experience: 1,600 hours (46 weeks working 35 hours per week) of paid work or internship experience (non-volunteer) with the elderly or physically disabled in an institutional or community setting.

Agency must be Medicaid approved.

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

Division of Aging and Community Services

Frequency of Verification:

Every two years

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of an unpaid, informal caregiver (those persons who normally provide unpaid care) for the participant. Federal financial participation is not 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.

Respite Care may be provided in the following location(s): 1) the Individual's home or place of residence; 2) a Medicaid certified Nursing Facility that has a separate Medicaid provider number to bill for Respite; 3) An other community care residence approved by the State that is not a private residence including only: an Assisted Living Residence (AL), a Comprehensive Personal Care Home (CPCH), or an Adult Family Care (AFC) Home

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

Respite is limited to 30 days per participant per Waiver year. Room and Board charges are included in Institutional Respite rate. The Medicaid Waiver Year starts October 1st. If 30 days of nursing facility Respite is

reached, but the participant needs to remain in the facility longer, the individual must be referred to the Regional Office of Community Choice Options for a short-term Pre Admission Screen (PAS).

Respite will not be reimbursed for individuals who reside permanently in an Assisted Living Residence or Comprehensive Personal Care Home or for GO participants that are admitted to the Nursing Facility.

Respite care shall not be reimbursed as a separate service during the hours the participant is participating in either Adult Day Health Services or Social Adult Day Care. Services excluded from additional billing while simultaneously receiving Respite care include: Chore, Home-Based Supportive Care, Home-delivered meals, and Personal Care Assistant.

Sitter, live-in, or companion services are not considered Respite Services and can not be authorized as such.

Respite services are not provided for formal, paid caregivers (i.e. Home Health or Certified Nurse Aides). Respite services are not to be authorized due to the absence of those persons who would normally provide paid care for the participant.

Respite care in a nursing facility requires a negative Pre Admission Screening Resident Review (PASRR) Level I screen prior to service authorization.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Family Care Sponsor Agencies
Agency	Licensed Employment Agency and Temporary Help Agency (In-home respite)
Agency	Licensed Health Care Service Firm (In-home respite)
Agency	Licensed, Certified Home Health Agency (In-home respite)
Agency	Licensed Assisted Living Residence (ALR) or Comprehensive Personal Care Home (CPCH)
Agency	Accredited, Registered Home Care Agency (In-home respite)
Individual	Licensed Adult Family Care (AFC) Caregiver
Agency	Licensed Nursing Facility

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Adult Family Care Sponsor Agencies

Provider Qualifications

License (specify):

NJAC 8:43B/NJSA 26:2Y-1

Certificate (specify):

N/A

Other Standard (specify):

Medicaid Approved

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

Department of Health and Senior Services

Frequency of Verification:

Every 24 months

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**

Agency

Provider Type:

Licensed Employment Agency and Temporary Help Agency (In-home respite)

Provider Qualifications**License (specify):**

NJAC 13:45B

NJSA 56:8-1.1

Certificate (specify):

N/A

Other Standard (specify):

Provides:

Copy of license; Evidence that Agency complies with all employer obligations under the law; Evidence of Liability Insurance and Worker's Compensation Coverage; Documentation that employees have undergone criminal background checks; Evidence that assigned worker has demonstrated competence in the task through documentation of formal training or education, previous experience, written documentation from previous employers, ability to clearly and effectively explain, verbally or in writing, specifically how the task is to be accomplished, or through actual observation of task performance.

The provider also signs an Agreement with the Department of Health and Senior Services to provide services to participants.

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

Department of Labor and Public Safety, Division of Consumer Affairs

Frequency of Verification:

Annual; Provides required evidence of qualifications and signs an agreement with the Department of Health and Senior Services prior to providing initial service.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**

Agency

Provider Type:

Licensed Health Care Service Firm (In-home respite)

Provider Qualifications**License (specify):**

NJAC 13:45B

Certificate (specify):

N/A

Other Standard (specify):

Provides Documentation that employees have complied with Participant-Employed Provider requirements listed in the Home-Based Supportive Care Service; Documentation that employees have undergone criminal background checks; Agency complies with all employer obligations under the law; Evidence of Liability Insurance and Worker's Compensation Coverage; Evidence that assigned worker has demonstrated competence in the task through documentation of formal training or education, previous experience, written documentation from previous employers, ability to clearly and effectively explain, verbally or in writing, specifically how the task is to be accomplished, or through actual observation of task performance. Provider signs an Agreement with the Department of Health and Senior Services to provide services to participants.

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

Department of Labor and Public Safety, Division of Consumer Affairs

Frequency of Verification:

Annual; Provides required evidence of qualifications and signs an agreement with the Department of Health and Senior Services prior to providing initial service.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Licensed, Certified Home Health Agency (In-home respite)

Provider Qualifications**License (specify):**

NJAC 8:42

Certificate (specify):

N/A

Other Standard (specify):

Medicaid Approved

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

Department of Health and Senior Services

Frequency of Verification:

Every two years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Licensed Assisted Living Residence (ALR) or Comprehensive Personal Care Home (CPCH)

Provider Qualifications**License (specify):**

NJAC 8:36

Certificate (specify):

N/A

Other Standard (specify):

Medicaid Approved

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

NJ Department of Health and Senior Services

Frequency of Verification:

Every 24 months

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**

Agency

Provider Type:

Accredited, Registered Home Care Agency (In-home respite)

Provider Qualifications**License (specify):**

NJAC 13:45B-14

Certificate (specify):

Commission on Accreditation for Home Care Inc. or National Association for Home Care and Hospice or Community Health Accreditation Program or the Joint Commission on Accreditation of Healthcare Organizations

Other Standard (specify):

Medicaid Provider

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

Accrediting Body

Frequency of Verification:

Annual

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**

Individual

Provider Type:

Licensed Adult Family Care (AFC) Caregiver

Provider Qualifications**License (specify):**

NJSA 26:2Y-1

Certificate (specify):

N/A

Other Standard (specify):

Medicaid approved

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

NJ Department of Health and Senior Services

Frequency of Verification:

Every 24 months

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Licensed Nursing Facility

Provider Qualifications**License (specify):**

NJAC 8:39

Certificate (specify):

N/A

Other Standard (specify):

Medicaid Approved

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

NJ Department of Health and Senior Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Family Care

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Adult Family Care (AFC) enables up to three unrelated individuals to live in the community in the primary residence of a trained caregiver who provides support and health services for the resident. Adult Family Care may provide personal care, meal preparation, transportation, laundry, errands, housekeeping, socialization and recreational activities, monitoring of participant's funds when requested by the participant, up to 24 hours a day of supervision, and medication administration.

The individual remains responsible for the cost of Room and Board and cost share, if applicable.

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

Individuals that opt for Adult Family Care do not receive Personal Care Assistant, Chore Service, Home-Delivered Meals, Home-Based Supportive Care, Caregiver/Participant Training, Assisted Living, or Assisted Living Program. Those services would duplicate services integral to and inherent in the provision of Adult Family Care services.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Adult Family Care (AFC) Caregiver
Agency	Licensed Adult Family Care (AFC) Sponsor Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Family Care

Provider Category:

Individual

Provider Type:

Licensed Adult Family Care (AFC) Caregiver

Provider Qualifications

License (specify):

Licensed by the New Jersey Department of Health and Senior Services pursuant to N.J. S. A 26:2Y as an Adult Family Care Caregiver

Certificate (specify):

N/A

Other Standard (specify):

Medicaid Approved; The caregiver and all non-participant members of the home, 18 years of age and older, must complete a State/Federal Criminal Background Investigation as a condition of participation prior to accepting a participant.

Verification of Provider Qualifications

Entity Responsible for Verification:

New Jersey Department of Health and Senior Services Division of Health Facility Evaluation and Licensure

Frequency of Verification:

Initially and every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Family Care

Provider Category:

Agency

Provider Type:

Licensed Adult Family Care (AFC) Sponsor Agency

Provider Qualifications

License (specify):

Licensed by the New Jersey Department of Health and Senior Services pursuant to N.J.S.A 26:2Y as an Adult Family Care Sponsor Agency. Types of agencies may include: Private, non-profit or proprietary agency, Adult Health Service Provider, Visiting Nurse Association, Homemaker Agency,

Hospital, or Nursing Home)

Certificate (specify):

N/A

Other Standard (specify):

The licensed Adult Family Care Sponsor Agency recruits, screens, trains, and approves the caregiver and the caregiver's home. The caregiver and all non-participant members of the home, 18 years of age and older, must complete a State/Federal Criminal Background Investigation as a condition of participation prior to accepting a participant.

Verification of Provider Qualifications

Entity Responsible for Verification:

New Jersey Department of Health and Senior Services Division of Health Facility Evaluation & Licensure

Frequency of Verification:

Initially and every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assisted Living (ALR or CPCH)

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Assisted Living means a coordinated array of supportive personal and health services, chore, medication administration, intermittent skilled nursing services, available 24 hours per day, to residents who have been assessed to need these services including persons who require nursing home level of care. A planned, diversified program of resident activities shall be offered daily for residents, including individual and/or group activities, on-site or off-site, to meet the individual needs of residents. Assisted Living facilities also either arrange or provide for transportation that is specified in the Plan of Care and periodic nursing evaluations. Assisted Living promotes resident self-direction and participation in decisions that emphasize independence, individuality, privacy, dignity, and homelike surroundings.

ALR "Assisted Living Residence" means a facility which is licensed by the Department of Health and Senior Services to provide apartment-style housing and congregate dining and to assure that assisted living services are available when needed, for four or more adult persons unrelated to the proprietor. Apartment units offer, at a minimum, one unfurnished room, a private bathroom, a kitchenette, and a lockable door on the unit entrance. CPCH "Comprehensive Personal Care Home" means a facility which is licensed by the Department of Health and Senior Services to provide room and board and to assure that assisted living services are available when needed, to four or more adults unrelated to the proprietor. Residential units in comprehensive personal care homes house no more than two residents and have a lockable door on the unit entrance.

Individuals in Assisted Living are responsible to pay their Room and Board costs at a rate established by the Department and any applicable cost share.

Residents in Assisted Living Facilities have access to both their own living unit's kitchen 24/7 and to a facility pantry with food and beverages 24/7.

Residents in Comprehensive Personal Care Homes have access to their own living unit's kitchen 24/7. In some situations, these kitchens may be modified to eliminate the cooking appliance. However their refrigerator and dry food storage is available.

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

Individuals that opt for Assisted Living do not receive Personal Care Assistant, Adult Family Care, Assisted Living Program, Environmental Accessibility Adaptations, Chore Services, Personal Emergency Response Services, Home-Delivered Meals, Caregiver/Participant Training, Adult Day Health Services, Social Adult Day Care, Attendant Care, Home-Based Supportive Care, or Respite as they would duplicate services integral to and inherent in the provision of Assisted Living services.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Comprehensive Personal Care Home (CPCH)
Agency	Assisted Living Residence (ALR)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living (ALR or CPCH)

Provider Category:

Agency

Provider Type:

Comprehensive Personal Care Home (CPCH)

Provider Qualifications

License (specify):

Assisted Living Facility licensed by the Department of Health and Senior Services pursuant to N.J.A.C. 8:36 as an Assisted Living Facility.

Certificate (specify):

N/A

Other Standard (specify):

Medicaid approved

Verification of Provider Qualifications

Entity Responsible for Verification:

New Jersey Department of Health and Senior Services Division of Health Facilities Evaluation & Licensing

Frequency of Verification:

Initially and every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living (ALR or CPCH)

Provider Category:

Agency

Provider Type:

Assisted Living Residence (ALR)

Provider Qualifications**License (specify):**

Assisted Living Facility licensed by the Department of Health and Senior Services pursuant to N.J.A.C. 8:36 as an Assisted Living Facility.

Certificate (specify):

N/A

Other Standard (specify):

Medicaid Approved

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

New Jersey Department of Health and Senior Services, Division of Health Facilities Evaluation & Licensing

Frequency of Verification:

Initially and every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assisted Living Program (ALP) in Subsidized Housing

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Assisted Living Program means the provision of or arrangement for meals and assisted living services to the tenants/residents of publicly subsidized housing. Assisted Living Services include personal care, homemaker, chore, and medication oversight and administration throughout the day.

Individuals reside in their own independent apartments. The individual is responsible for his or her own rent and utility payments as defined in a lease with the landlord. Individuals are also responsible for the cost of meals and other household expenses.

Again, Assisted Living Program means the provision of or arrangement for meals and assisted living services to the tenants/residents of publicly subsidized housing. Assisted Living Program services are provided to individuals who reside in their own independent apartments. The ALP individual is responsible for his or her own rent and utility payments as defined in a lease with the landlord.

Having an ALP provider offers the subsidized housing tenants the opportunity to remain in their own apartments

with the support of others, while maintaining their independence dignity.

Participation in the services of an Assisted Living Program (ALP) are voluntary on the part of any tenant of any ALP contracted publicly subsidized housing building.

The ALP is to make available dining services and/or meal preparation assistance to meet the daily nutritional needs of residents.

ALP providers work with participants to ensure a strong sense of connectedness in each apartment community as well as with the larger communities in which they are located. Individuals may participate in tenant/resident meetings, attend community-based civic association meetings and plan recreational activities. Sometimes, ALP providers host community health screening events to encourage wellness for the tenant population at large.

By state regulation, ALP providers are required to have procedures for arranging resident transportation to and from health care services provided outside of the program site, and shall provide reasonable plans for security and accountability for the resident and his or her personal possessions.

Additionally, a planned, diversified program of activities is to be posted and offered daily for residents, including individual and/or group activities, on-site or off-site to meet the service needs of residents.

Because ALPs are located in independent subsidized housing, tenants are free to be as actively involved in their communities as they desire to be. ALP buildings often have relationships with community partners and local strategic alliances that create conditions to promote increased access, inclusiveness, and tenant engagement in local happenings as well as, better health and wellness services and opportunities for tenants.

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

Individuals that opt for Assisted Living Program do not receive Personal Care Assistant, Adult Day Health Services, Chore Service, Attendant Care, Home-Based Supportive Care, Caregiver/Participant Training, Assisted Living, or Adult Family Care as they would duplicate services integral to and inherent in the provision of Assisted Living Program services. The subsidized housing provider is responsible for Environmental Accessibility Adaptations.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assisted Living Program in Subsidized Housing

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assisted Living Program (ALP) in Subsidized Housing

Provider Category:

Agency

Provider Type:

Assisted Living Program in Subsidized Housing

Provider Qualifications

License (specify):

Licensed by the New Jersey Department of Health and Senior Services pursuant to NJAC 8:36

Certificate (specify):

N/A

Other Standard (specify):

Medicaid approved

Verification of Provider Qualifications

Entity Responsible for Verification:

New Jersey Department of Health and Senior Services, Division of Health Facilities Evaluation & Licensing

Frequency of Verification:

Initially and every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Attendant Care

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Hands-on care (needs physical assistance to accomplish task), of both a supportive and health-related nature, specific to the needs of a medically stable physically disabled individual, who is capable of self directing his or her own health care. Supportive services are those that substitute for the absence, loss, diminution, or impairment of a physical function.

This service is intended to assist individuals in accessing care of a more health related nature, beyond basic Activities of Daily Living/Instrumental Activities of Daily Living (ADL/IADL). This service may include skilled or nursing care to the extent permitted by State law. Supervision must be furnished directly by the participant when the person has been trained to perform this function and when the safety and efficacy of participant-provided supervision has been certified in writing by a Registered Nurse or otherwise as provided in State law. This certification must be based on direct observation of the participant and the specific attendant care provider by the Registered Nurse evaluator, during the actual provision of care.

Housekeeping activities that are incidental to the performance of care may also be furnished as part of this activity.

Attendant Care may ONLY be provided by a Participant-Employed Provider. Attendant Care is not available in Assisted Living, Adult Family Care or Assisted Living Program as it would duplicate services furnished through the Assisted Living, Adult Family Care and Assisted Living Program service packages.

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

Attendant Care is limited to a total of 40 hours per week.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Participant Employed Provider (PEP)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Attendant Care

Provider Category:

Individual

Provider Type:

Participant Employed Provider (PEP)

Provider Qualifications

License (specify):

N/A

Certificate (specify):

Registered Nurse observes the Participant-Employed Provider during the actual provision of care and confirms in writing that Participant-Employed Provider can perform the task for a participant who has been determined by a Registered Nurse as capable of directing his or her own care.

Other Standard (specify):

18 years old

Successfully completes a criminal background check

United States citizen or a legal alien authorized to work in the United States

Able to communicate with the participant

Physically capable of performing the service

PEP Provider must be approved by Participant, Care Manager, Criminal Background Investigation and Fiscal Intermediary to work as an employee of participant and demonstrates competency to complete required task.

Respects the rights of the participant

Is able to read and write at a level sufficient to follow written instructions and maintain records required in the performance of their duties

Must meet and demonstrate competency standards for the task as determined by a Registered Nurse.

Must be certified by participant as capable of performing the task

Agrees to provide the approved tasks in the amount, duration and frequency requested by the participant and approved by the Care Manager at the agreed rate of reimbursement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Registered Nurse

Frequency of Verification:

Prior to the performance of the task to be performed.

Care Manager reevaluates participant at least annually and if participant's ongoing ability to direct task is questionable, requests a second Registered Nurse evaluation.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Caregiver Participant Training

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Instruction provided to a client or caregiver in either a one-to-one or group situation to teach a variety of skills necessary for independent living, including: use of specialized or adaptive equipment, completion of medically related procedures required to maintain the participant in a home or community setting; activities of daily living; adjustment to mobility impairment; management of personal care needs; skills to deal with care providers and attendants. Training needs must be identified through the comprehensive evaluation, re-evaluation, or in a professional evaluation and must be identified in the approved Plan of Care as a required service.

Caregiver/Participant Training is not available to participants that have chosen Assisted Living, Adult Family Care, or the Assisted Living Program as it would duplicate services furnished through Assisted Living, Adult Family Care or Assisted Living Program.

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

Caregiver Participant Training is not considered a service that can be received monthly by GO participants.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual with appropriate expertise (i.e. RN, OT) to train the recipient/caregiver as required by the Plan of Care
Agency	Homemaker Agency with Health Care Service Firm
Agency	Centers for Independent Living (CIL)
Agency	Health Care Service Firm
Agency	Licensed Medicare Certified Home Health Agency
Agency	Adult Family Care Sponsor Agency
Agency	Proprietary or Not-for-Profit Business entity

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Caregiver Participant Training

Provider Category:

Individual

Provider Type:

Individual with appropriate expertise (i.e. RN, OT) to train the recipient/caregiver as required by the Plan of Care

Provider Qualifications**License (specify):**

If required by scope of practice, e.g., Registered Nurse pursuant to NJSA 45:11-26

Certificate (specify):

If required by scope of practice, e.g. Occupational Therapist

Other Standard (specify):

Individual in field not requiring license, certification, or registration must submit credentials (appropriate experience and expertise) in subject matter for approval.

Provides required evidence of qualifications and has a signed agreement with the Department of Health and Senior Services prior to providing specific service.

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

Division of Aging and Community Services

Frequency of Verification:

Provides required evidence of qualifications and signs an agreement with the Department of Health and Senior Services prior to providing initial service

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Caregiver Participant Training

Provider Category:

Agency

Provider Type:

Homemaker Agency with Health Care Service Firm

Provider Qualifications**License (specify):**

NJAC 13:35B

Certificate (specify):

N/A

Other Standard (specify):

Is Accredited by Commission on Accreditation for Home Care Inc., National Association for Home Care and Hospice, the Community Health Accreditation Program, or the Joint Commission on Accreditation of Healthcare Organizations

Training Curriculum/curricula

Trainer's credentials, to include License, Certification, or Registration if required by scope of practice

Evidence of Business Insurance, including Worker's compensation

Fee Schedule

Provides required evidence of qualifications and has a signed agreement with the Department of Health and Senior Services prior to providing specific service.

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

Department of Health and Senior Services per NJAC 13:35B

Division of Aging and Community Services

National Home Caring Council, Commission on Accreditation for Home Care Inc., or the Community Health Accreditation

Frequency of Verification:

Provides required evidence of qualifications and signs an agreement with the Department of Health and Senior Services prior to providing initial service.

Accrediting Body verifies qualifcaitons Annually

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Caregiver Participant Training

Provider Category:

Agency

Provider Type:

Centers for Independent Living (CIL)

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

Must comply with Section 705 of the Federal Rehabilitation Act 1973, as amended.

Submits annual 704 report to the US Department of Education

Provides required evidence of qualifications and signs an agreement with the Department of Health and Senior Services prior to providing specific service.

Verification of Provider Qualifications

Entity Responsible for Verification:

New Jersey Dept. of Law and Public Safety per NJAC 13:45 B

Division of Aging and Community Services

Frequency of Verification:

Provides required evidence of qualifications and signs an agreement with the Department of Health and Senior Services prior to providing initial service.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Caregiver Participant Training

Provider Category:

Agency

Provider Type:

Health Care Service Firm

Provider Qualifications

License (specify):

NJAC 13:45B

Certificate (specify):

N/A

Other Standard (specify):

Business entity with evidence of authority, e.g. New Jersey Tax Certificate or Trade Name Registration; and Ownership

Training Curriculum/Curricula

Trainer's credentials, to include License, Certification, or Registration if required by scope of practice

Evidence of Business Insurance, including Worker's compensation

Fee Schedule

Provides required evidence of qualifications and has a signed agreement with the Department of Health and Senior Services prior to providing specific service.

Verification of Provider Qualifications

Entity Responsible for Verification:

New Jersey Dept. of Law and Public Safety per NJAC 13:45 B
Division of Aging and Community Services

Frequency of Verification:

Provides required evidence of qualifications and signs an agreement with the Department of Health and Senior Services prior to providing initial service.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Caregiver Participant Training

Provider Category:

Agency

Provider Type:

Licensed Medicare Certified Home Health Agency

Provider Qualifications

License (specify):

Per NJAC 8:42

Certificate (specify):

CMS

Other Standard (specify):

Must have training curriculum/curricula

Trainer's credentials, to include License, Certification, or Registration if required by scope of practice

Evidence of Business Insurance, including Workman's Compensation

Fee Schedule

Provides required evidence of qualifications and has a signed agreement with the Department of Health and Senior Services prior to providing specific service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Senior Services per NJAC 8:42

CMS

Division of Aging and Community Services

Frequency of Verification:

Provides required evidence of qualifications and signs an agreement with the Department of Health and Senior Services prior to providing initial service

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Caregiver Participant Training

Provider Category:

Agency

Provider Type:

Adult Family Care Sponsor Agency

Provider Qualifications

License (specify):

NJSA 26:2Y

Certificate (specify):

N/A

Other Standard (specify):

Training Curriculum/Curricula

Trainer's credentials, to include License, Certification, or Registration if required by scope of practice

Evidence of Business Insurance, including Worker's compensation

Fee Schedule

Provides required evidence of qualifications and has a signed agreement with the Department of Health and Senior Services prior to providing specific service.

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

New Jersey Department of Health and Senior Services per NJSA 26:2Y

Division of Aging and Community Services

Frequency of Verification:

Every two years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Caregiver Participant Training****Provider Category:**

Agency

Provider Type:

Proprietary or Not-for-Profit Business entity

Provider Qualifications**License (specify):**

N/A

Certificate (specify):

N/A

Other Standard (specify):

Provides required evidence of authority to conduct such business in New Jersey, i.e., New Jersey Tax

Certificate or Trade Name Registration, and Ownership

Training Curriculum/Curricula

Trainer's credentials, to include License, Certification, or Registration if required by scope of practice

Evidence of Business Insurance, including Worker's compensation

Fee Schedule

Provides required evidence of qualifications and has a signed agreement with the Department of Health and Senior Services prior to providing specific service.

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

Division of Aging and Community Services

Frequency of Verification:

Provides required evidence of qualifications and signs an agreement with the Department of Health and Senior Services prior to providing initial service.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Chore Services

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Services needed to maintain the home in a clean, sanitary and safe environment. The chores are non-continuous, non-routine heavy household maintenance tasks intended to increase the safety of the individual. Chore services include cleaning appliances, cleaning and securing rugs and carpets, washing walls, windows, and scrubbing floors, cleaning attics and basements to remove fire and health hazards, clearing walkways of ice, snow, leaves, trimming overhanging tree branches, replacing fuses, light bulbs, electric plugs, frayed cords, replacing door locks, window catches, replacing faucet washers, installing safety equipment, seasonal changes of screens and storm windows, weather stripping around doors, and caulking windows.

Chore Services do not include normal everyday housekeeping tasks such as dusting, vacuuming, changing bed linens, washing dishes, cleaning the bathroom, etc.

Chore is not a service that would be received monthly by a GO participant.

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

Chore service is not available to those who opt for Assisted Living, Adult Family Care, or Assisted Living Program as it is included in the Assisted Living, Adult Family Care and Assisted Living Program service packages.

Chore services are appropriate only when neither the participant, nor anyone else in the household, is capable of performing the chore; there is no one else in the household capable of financially paying for the chore service; and there is no relative, caregiver, landlord, community agency, volunteer, or 3rd party payer capable or responsible to complete this chore.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Participant-Employed Provider (PEP)
Agency	Congregate Housing Services Program
Individual	Private Contractor
Agency	Subsidized Independent Housing for Seniors

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Individual

Provider Type:

Participant-Employed Provider (PEP)

Provider Qualifications**License (specify):**

N/A

Certificate (specify):

N/A

Other Standard (specify):

18 years old

Successfully completes a criminal background check

United States citizen or a legal alien authorized to work in the United States

Able to communicate with the participant

Physically capable of performing the service

Is able to read and write at a level sufficient to follow written instructions and maintain records required in the performance of their duties

Respects the rights of the participant

Participant-Employed Provider must be approved by Participant, Care Manager, Criminal Background Investigation and Fiscal Intermediary to work as an employee of participant and demonstrates competency to complete required task.

Agrees to provide the approved tasks in the amount, duration and frequency requested by the participant and approved by Care Manager at the agreed rate of reimbursement.

Be certified by participant and approved by Care Manager as competent for the task.

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

Care Manager, and Division of Aging & Community Services (DACS)

Frequency of Verification:

Care Manager and participant reevaluate at least annually.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Chore Services****Provider Category:**

Agency

Provider Type:

Congregate Housing Services Program

Provider Qualifications**License (specify):**

N/A

Certificate (specify):

N/A

Other Standard (specify):

Public Law 1981 chapter 553

Provides required evidence of qualifications and signs an agreement with the Department of Health and Senior Services to provide services prior to providing initial service

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

Division of Aging and Community Services

Frequency of Verification:

Provides required evidence of qualifications and signs an agreement with the Department of Health and Senior Services to provide services prior to providing initial service

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Individual

Provider Type:

Private Contractor

Provider Qualifications**License (specify):**

N/A

Certificate (specify):

N/A

Other Standard (specify):

Provides required evidence that it:

Is a business entity with evidence of authority to conduct such business in NJ, i.e. New Jersey Tax Certificate or Trade Name Registration

Has any license required by law to engage in the service, provide equipment

Has Product/business Insurance, Including Worker's Compensation

Has a Business product/service literature

Has a Fee Schedule

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

Division of Aging and Community Services

Frequency of Verification:

Provides required evidence of qualifications and signs an agreement with the Department of Health and Senior Services to provide services prior to providing initial service

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Agency

Provider Type:

Subsidized Independent Housing for Seniors

Provider Qualifications**License (specify):**

N/A

Certificate (specify):

N/A

Other Standard (specify):

NJSA 52:27D-184 qualified Housing Agency

Provides required evidence of qualifications and signs an agreement with the Department of Health and Senior Services to provide services prior to providing initial service

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

Division of Aging and Community Services

Frequency of Verification:

Provides required evidence of qualifications and signs an agreement with the Department of Health and Senior Services to provide services prior to providing initial service

Appendix C: Participant Services

3.1.3. Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition Services

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Community Transitions Services (CTS) are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to an Assisted Living Facility, Adult Family Care home or a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary accessibility adaptations; and (g) activities to assess need, arrange for and procure need resources. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan, and the person is unable to meet such expense or when the services cannot be obtained from other sources.

Community Transition Services may be furnished as a Waiver service to individuals to facilitate the transition from an institution to a more independent/less restrictive living arrangement.

Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

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

Community Transition Services are non-recurring and available one time only per person. If a participant returns to the Nursing Home, remains there for any period of time, and wishes to return again to the community, he or she may do so and participate in the Waiver, but Community Transition Services will not be a Waiver service the person may utilize again.

Community Transition Services may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

All Community Transition Services are prior authorized by the Division of Aging and Community Services' Central Office and not considered in the monthly spending cap.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Private Contractor/Business

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Individual

Provider Type:

Private Contractor/Business

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

Provides required evidence that it:

Is a business entity with evidence of authority to conduct such business in New Jersey, i.e. New Jersey Tax Certificate or Trade Name Registration

Has any license required by law to engage in the service, provide furnishings, appliances, equipment

Has Product/business Insurance, Including Worker's Compensation

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Community Services

Frequency of Verification:

Provides required evidence of qualifications and signs an agreement with the Department of Health and Senior Services prior to providing initial service.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations (EAA)

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's Plan of Care which are necessary to ensure the health, safety and welfare of the participant and enable the participant to function with greater independence in the home, without which the participant would require institutionalization.

Adaptations may include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electrical and plumbing systems necessary to accommodate the medical equipment and supplies essential for the participant's welfare. Excluded are those adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the participant, including but not limited to items such as carpeting, roof repairs and central air conditioning. Adaptation to vehicles (vehicle modifications) are excluded and not a covered service. Adaptations which add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g. in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a participant's wheelchair. All services shall be provided in accordance with applicable State, Local and Americans with Disability Act (ADA) and/or ADA Accessibility Guidelines (ADAAG) and Specifications.

Per Olmstead Letter #3, assessments for the accessibility and need for modifications to a participant's home may be included as an expense in the EAA Waiver Service as a relevant service by another provider such as a home health agency or occupational therapist.

Evidence of permits, approvals or authorizations must be made available if required.

Participants living in licensed residences (ALR, CPCH, ALP, Class B Boarding Homes) are not eligible to receive EAAs. Modifications to public apartment buildings and/or rental properties are the responsibility of the owner/landlord and excluded from this benefit. Environmental accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services, except for approved Adult Family Care (AFC) Caregivers' homes as assessed to be needed by GO program participants.

EAAs are not comparable or equivalent to Vehicle Modifications. Vehicle modifications are not a covered waiver service for GO participants.

EAAs are not considered a waiver service that a participant can receive on a monthly basis.

A minimum of two estimates are required by approved Waiver providers reflecting the EAA's total cost. Total cost includes all materials, labor, equipment, shipping fees, permits or any other expenditures to be incurred from the initiation phase to the completion phase of the EAA modification. Authorized EAA costs do not include potential removal fees of the modification.

All home modifications are limited based on the participant's assessed need for an EAA. The adaptation will represent the most cost effective means to meet the needs of the participant. The adaptation will be specific to, but not in excess of, the participant's needs. If another service, such as a State Plan Service or other Waiver service (i.e. Specialized Medical Equipment and Supplies) will meet the same need for which an EAA is being proposed, the SME will be the authorized service.

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

Environmental Accessibility Adaptations that cost \$500 or more must be prior authorized by the Division of Aging and Community Services. The cost of the Environmental Accessibility Adaptation is outside the participant's individual spending cap.

If the EAA cost is over \$500, a minimum of two independent cost estimates must be submitted to the Division of Aging and Community Services (DACs). If the estimates are far apart in cost, a revision or third estimate may be necessary. Estimates must include the approved provider's contact information. A description of work to be done to include pictures/schematics if appropriate and will also detail materials and labor costs. The estimate is to include a Physicians Order if appropriate indicating the service needed and the medical rationale for the service. Also, a letter from the owner of the property approving the modification to the property and acknowledging that the State is not responsible for the removal of the modification from the property is required.

Environmental Accessibility Adaptations are limited to \$5,000 per participant per Waiver year. Additional modification costs exceeding those limits may be requested if a participant's health and safety require special consideration, however, the service of EAA is subject to a \$10,000 lifetime cost cap for each participant assessed

to require such adaptation(s).

For those individuals who are in need of Environmental Accessibility Adaptations to transition from a nursing facility to the community, the State may initiate the adaptations up to 180 days prior to actual discharge but authorization of the EAA and reimbursement of the service will not be reimbursed until program enrollment has occurred.

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

- Participant-directed as specified in Appendix E
 Provider managed

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

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Private Contractor/Business

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Accessibility Adaptations (EAA)

Provider Category:

Individual

Provider Type:

Private Contractor/Business

Provider Qualifications

License (*specify*):

N/A

Certificate (*specify*):

N/A

Other Standard (*specify*):

Provides required evidence that it:

Is a business entity with evidence of authority to conduct such business in New Jersey, i.e. New Jersey Tax Certificate or Trade Name Registration

Has any license required by law to engage in the service, e.g. Master Plumbers, General Contractor

Has Product/business Insurance, Including Worker's Compensation

NJAC 5:23-2

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Community Services/Care Manager

Frequency of Verification:

Provides required evidence of qualifications and signs an agreement with the Department of Health and Senior Services prior to providing initial service.

Care Manager verifies credentials prior to submitting bid.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home-Based Supportive Care

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Services designed to reduce or prevent inappropriate institutionalization by maintaining, strengthening, or restoring an individual's functioning. Needs must be identified through the validated InterRAI comprehensive level of care evaluation tool or re-evaluation, and must be itemized in the approved Plan of Care as a required service. All services include the provision of non-medical transportation necessary for the implementation of the Plan of Care.

Home-Based Supportive Care is not a duplication of the State Plan of Personal Care Assistant. According to N.J.A.C. 10:60-1.2, Personal care assistant services means "health related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a Registered Nurse, as certified by a physician in accordance with a beneficiary's written plan of care." PCA services are prior authorized by the Division of Disability Services in the Department of Human Services. In Home-Based Supportive Care, the services listed in the next paragraph are authorized by the Care Manager based on the needs identified in the initial Level of Care Evaluation and include services beyond "health-related."

Home-Based Supportive Care includes providing assistance with Activities of Daily Living: bathing, dressing, toileting, transferring, eating, bed mobility, and locomotion, either hands-on (needs physical assistance to accomplish the task) or through supervision and cueing. Home-Based Supportive Care also includes assistance with Instrumental Activities of Daily Living (IADL): preparing meals, shopping, managing money, housework, laundry, medication administration, transportation, and mobility outside the home.

Home-Based Supportive Care may be provided by an approved Agency or a Participant-Employed Provider (PEP) selected and hired by the participant.

Individuals will receive Options Counseling from the Office of Community Choice Options Community Choice Counselors and/or County Assessors to assure that the individual has the choice between Home-Based Supportive Care and the State Plan Personal Care Assistant Service.

Home-Based Supportive Care is not available in an Assisted Living Facility, Adult Family Care Home, or Assisted Living Program as it would duplicate services required in Assisted Living, Adult Family Care, or Assisted Living Program.

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

Home-Based Supportive Care is limited to 40 hours a week. If a participant selects Home-Based Supportive Care, he or she is then excluded from receiving Personal Care Assistant.

Home-Based Supportive Care is not reimbursed when the participant is hospitalized or institutionalized.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Subsidized Independent Housing for Seniors
Agency	Licensed Medicare Certified Home Health Agency
Agency	Homemaker Agency that has Health Care Service Firm license
Agency	Licensed Health Care Service Firm
Individual	Participant Employed Provider (PEP)
Agency	Licensed Employment Agency or Temporary Help Agency
Agency	Congregate Housing Services Program

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home-Based Supportive Care

Provider Category:

Agency

Provider Type:

Subsidized Independent Housing for Seniors

Provider Qualifications

License (specify):

NJSA 52:27D-184

Certificate (specify):

N/A

Other Standard (specify):

Provides required evidence of Liability Insurance and Worker's Compensation

Individual worker meets competence requirements necessary to performance of task as defined in Health Care Service Firm requirements above.

Signs an Agreement with the Department of Health and Senior Services to provide specific Services to participants.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Community Services

Frequency of Verification:

Signs an agreement with the Department of Health and Senior Services that it meets standards prior to providing initial service.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home-Based Supportive Care

Provider Category:

Agency

Provider Type:

Licensed Medicare Certified Home Health Agency

Provider Qualifications

License (specify):

NJAC 8:42

Certificate (specify):

CMS

Other Standard (specify):

Medicaid approved

Verification of Provider Qualifications

Entity Responsible for Verification:

CMS

Frequency of Verification:

Every two years

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home-Based Supportive Care

Provider Category:

Agency

Provider Type:

Homemaker Agency that has Health Care Service Firm license

Provider Qualifications

License (specify):

NJAC 13:45B

Certificate (specify):

N/A

Other Standard (specify):

Provides proof of Accreditation by National Home Caring Council, Commission on Accreditation for Home Care Inc., or the Community Health Accreditation Program

Valid Medicaid provider number

Evidence of Liability Insurance & Worker's compensation

Verification of Provider Qualifications

Entity Responsible for Verification:

Accreditation Agency

State Fiscal Agent

Frequency of Verification:

Annually for Accreditation

State Fiscal Agent periodically

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home-Based Supportive Care

Provider Category:

Agency

Provider Type:

Licensed Health Care Service Firm

Provider Qualifications

License (specify):

NJAC 13:45B

Certificate (specify):

N/A

Other Standard (specify):

Documentation that employees have complied with Participant-Employed Provider requirements listed above

Documentation that employees have undergone criminal background checks

Agency complies with all employer obligations under the law
 Evidence of Liability Insurance and Worker's Compensation Coverage
 Evidence that assigned worker has demonstrated competence in the task through documentation of formal training or education; previous experience; written documentation from previous employers; ability to clearly and effectively explain, verbally or in writing, specifically how the task is to be accomplished; or through actual observation of task performance.

Signs an Agreement with the Department of Health and Senior Services to provide services to participants.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Labor and Public Safety, Division of Consumer Affairs

Frequency of Verification:

Annual

Provides required evidence of qualifications and signs an agreement with the Department of Health and Senior Services prior to providing initial service.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home-Based Supportive Care

Provider Category:

Individual

Provider Type:

Participant Employed Provider (PEP)

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

18 years old

Successfully completes a criminal background check

US citizen or a legal alien authorized to work in the US

Able to communicate with the participant

Physically capable of performing the service

Respect the rights of the participant

Participant-Employed Provider must be approved by Participant, Care Manager, Criminal

Background Investigation and Fiscal Intermediary to work as an employee of participant and demonstrate competency to complete required task.

Be able to read & write at a level sufficient to follow written instructions and maintain records required in the performance of their duties

Evidence that assigned worker has demonstrated competence in the task

through documentation of formal training or education; previous experience; written documentation from previous employers; ability to clearly and effectively explain, verbally or in writing, specifically how the task is to be accomplished; or through actual observation of task performance

Be certified by participant and approved by Care Manager as competent for the task.

Agrees to provide the approved tasks in the amount, duration and frequency requested by the participant and approved by Care Manager at the agreed rate of reimbursement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant, Care Manager, Department of Health and Senior Services Division of Health Facilities Evaluation & Licensure (HFEL), and the DACS contracted Fiscal Intermediary

Frequency of Verification:

Participant/Care Manager/Health Facilities Evaluation and Licensure/Fiscal Intermediary prior to service delivery; criminal background investigation ongoing and prints re-submitted for Federal check every two years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Home-Based Supportive Care

Provider Category:

Agency

Provider Type:

Licensed Employment Agency or Temporary Help Agency

Provider Qualifications**License (specify):**

NJAC 13:45B

NJSA 56:8-1.1

Certificate (specify):

N/A

Other Standard (specify):

Provides:

Copy of license

Evidence that Agency complies with all employer obligations under the law

Evidence of Liability Insurance and Worker's Compensation coverage

Documentation that employees have undergone criminal background checks

Evidence that assigned worker has demonstrated competence in the task through documentation of

formal training or education; previous experience; written documentation from previous employers;

ability to clearly and effectively explain, verbally or in writing, specifically how the task is to be

accomplished; or through actual observation of task performance.

Signs an Agreement with the Department of Health and Senior Services to provide services to

participants.

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

Department of Labor and Public Safety, Division of Consumer Affairs

Frequency of Verification:

Annual

Provides required evidence of qualifications and signs an agreement with the Department of Health and Senior Services prior to providing initial service.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Home-Based Supportive Care

Provider Category:

Agency

Provider Type:

Congregate Housing Services Program

Provider Qualifications**License (specify):**

Public Law 1981

Chapter 553

Certificate (specify):

N/A

Other Standard (specify):

Provides required evidence of Liability Insurance and Worker's Compensation

Individual Worker meets competence requirements as defined in Health Care Service Firm requirements above

Signs an Agreement with the Department of Health and Senior Services to provide specific services to participants.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Community Services

Frequency of Verification:

Signs an agreement with the Department of Health and Senior Services that it meets standards prior to providing initial service..

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home-Delivered Meals

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Nutritionally balanced meals delivered to the participant's home when this meal provision is more cost effective than having a personal care provider prepare the meal. These meals do not constitute a full nutritional regimen, but each meal shall provide at least 1/3 of the current Recommended Dietary Allowance established by the Food & Nutrition Board of the National Academy of Sciences, and National Research Council.

When the participant's needs cannot be met by a Title III (Area Plan Contract) provider due to: geographic inaccessibility, special dietary needs, the time of day or week the meal is needed, or existing Title III provider waiting lists precluding service delivery, a meal may be provided by restaurants, cafeterias, or caterers who comply with the New Jersey State Department of Health and Senior Services and local Board of Health regulations for food service establishments. The need for this service must be specified in the participant's Plan of Care, and the unavailability of other resources to satisfy this need must be documented in the case record.

Home-Delivered Meals are not provided in an Assisted Living Facility or Adult Family Care as meal provision is included in the Assisted Living Facility or Adult Family Care service package. A Home-Delivered Meal is not to be used to replace the regular form of "board" associated with routine living in an Assisted Living Facility or Adult Family Care Home. Waiver participants eligible for non-Waiver nutritional services would access those services first.

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

A unit of service equals one meal.

Home-delivered meals are provided to an individual at home, and included in the Plan of Care only when the participant is unable to leave the home independently, unable to prepare the meal, and there is no other person, paid or unpaid, to prepare the meal.

No more than one meal per day will be reimbursed under the GO Waiver.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Title III Approved Provider of Meal Service
Individual	Restaurant or Food Service Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home-Delivered Meals

Provider Category:

Agency

Provider Type:

Title III Approved Provider of Meal Service

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

Has a contract with Area Agency on Aging to provide meals

Provides a fee schedule

Signs agreement with the Department of Health and Senior Services to provide meals according to the terms of the agreement

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging/Division of Aging and Community Services

Frequency of Verification:

Prior to providing Service and annually (Area Agency on Aging)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home-Delivered Meals

Provider Category:

Individual

Provider Type:

Restaurant or Food Service Vendor

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

Commercial recording identification as a food establishment with authority to conduct such business in New Jersey, I.e. New Jersey Tax Certificate of Trade Name Registration; and ownership

Provides required evidence of compliance with NJAC 8:24
 Provides required evidence of Business Insurance, including Worker's Compensation
 Provides Service Literature
 Provides Fee Schedule
 Signs agreement with the Department of Health and Senior Services to provide meals according to the terms of the agreement

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Senior Services/Division of Aging and Community Services

Frequency of Verification:

Prior to providing service to participant

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System (PERS)

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Personal Emergency Response System is an electronic device, which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. Personal Emergency Response System. Trained professionals staff the response center.

A Personal Emergency Response System unit may also include an electronic medication-dispensing device that allows for a set amount of medications to be dispensed as per the dosage instructions. If the medication is not removed from the unit in a timely manner the unit will "lock" that dosage, not allowing the participant access to the missed medication. Before locking, the unit will use a series of verbal and/or auditory reminders that the participant is to take his or her medication. If there is no response, a telephone call will be made to the participant, participant's contact person, and care management site in that order until a "live" person is reached.

Installation, upkeep and maintenance of device/systems is provided.

Personal Emergency Response System is not available to individuals residing in Assisted Living Facilities (ALF) as it would duplicate services intrinsic to Assisted Living Facilities.

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

Personal Emergency Response System services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Electronic communication equipment vendor & monitoring staff

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Electronic communication equipment vendor & monitoring staff

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

Must submit evidence that it meets the following criteria:

Business entity with evidence of authority to conduct such business in New Jersey, i.e. New Jersey

Tax Certificate or Trade Name Registration

Any license required by law to engage in the service/installation

Evidence of Product/Business Insurance, including Worker's compensation

Business product/service literature

Fee Schedule

System Information including UL 1635/1637 compliance, system redundancy information

Evidence that the response center is Staffed by trained professionals

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Community Services

Frequency of Verification:

Provides required evidence of qualifications and signs an Agreement with the Department of Health and Senior Services prior to provision of service

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:
Social Adult Day Care

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Social Adult Day Care (SADC) is a community-based group program designed to meet the needs of adults with functional impairments through an individualized Plan of Care. Social Adult Day Care is a structured comprehensive program that provides a variety of health, social and related support services in a protective setting during any part of a day but less than 24-hour care.

Individuals who participate in Social Adult Day Care attend on a planned basis during specified hours. Social Adult Day Care assists its participants to remain in the community, enabling families and other caregivers to continue caring at home for a family member with impairment.

Social Adult Day Care services shall be provided for at least five consecutive hours daily, exclusive of any transportation time, up to five days a week.

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

Social Adult Day Care services shall be provided for at least five consecutive hours daily, exclusive of any transportation time, up to five days a week.

Social Adult Day Care is not available to those residing in an Assisted Living Facility as it would duplicate services required by the Assisted Living Licensing Regulations.

Social Adult Day Care cannot be combined with Adult Day Health Services.

The individual has no specific medical diagnosis requiring the oversight of an RN while in attendance at the Social Adult Day Care.

Assisted Living Program (ALP) participants, not ALR or CPCH participants, may attend Social Adult Day Care 2 (two) days a week, and (3) three days with prior authorization by the Division of Aging and Community Services' County Liaison/Quality Assurance Specialist.

Adult Family Care (AFC) participants may attend Social Adult Day Care 2 (two) days a week, and (3) three days with prior authorization by the Division of Aging and Community Services' County Liaison/Quality Assurance Specialist.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Social Adult Day Care

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Social Adult Day Care

Provider Category:

Agency

Provider Type:

Social Adult Day Care

Provider Qualifications**License (specify):**

N/A

Certificate (specify):

N/A

Other Standard (specify):

The provider must be a Medicaid approved entity that meets the following qualifications:

- Facility that (a) has a license or occupancy permit available, (b) has police and fire department response agreements, and (c) has written safety and emergency management policies and procedures.
- Personnel: (a) Program director designated, (b) has adequate Staff to meet program needs of target population, and (c) and at a minimum, has identified a nurse consultant.
- Client population: Established criteria for target population based on resources and program capabilities of facility.
- Program activities: Planned and ongoing age appropriate activities based on social, physical, and cognitive needs of the target population.
- Individualized Plans of Care: Based on identified individual client needs, jointly developed with client and family.
- Social Services: Coordination with, and referrals to, available community agencies and services. Staff has periodic contact with families.
- Nutrition: Provides a minimum of one nutritionally balanced meal per day. Special diet needs are met. Snacks provided as necessary.
- Health Management: (a) An initial health profile is completed. (b) Monthly weights are taken and other health related observations are recorded as necessary.
- Personal Care: Personal assistance as needed with mobility and activities of daily living.
- Possesses business authority to conduct such business in New Jersey and is in compliance with all applicable laws, codes, and regulations, including physical plant requirements, fire safety and ADA compliance.

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

County Office on Aging (Area Agency on Aging) or the Department of Health and Senior Services' Division of Aging and Community Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment and Supplies

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Specialized medical equipment and supplies is also a State Plan Service, but the scope of the Waiver coverage is materially different from the State plan service and the providers of the Waiver service may be different from the providers of the State plan service.

Specialized medical equipment (SME) and supplies as a Waiver service include (a) devices, controls, or appliances, specified in the Plan of Care, which enable individuals to increase their abilities to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State plan. Items reimbursed with Waiver funds are in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items, which are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

SME items reimbursed with Waiver funds are in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items, which are not of direct medical or remedial benefit to the participant.

For verification of SME items covered in the State Plan, the Care Manager must contact the Medical Assistance Customer Center (MACC) in the applicable county.

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

Specialized medical equipment and supplies that cost \$250 or more (such as a lift chair) require prior authorization by the Division of Aging and Community Services' Central Office Staff and are not included in the spending cap.

SME, as a GO Waiver service, do not include supplies that are already included in the per diem reimbursement for the Assisted Living Program in Subsidized Housing, the Assisted Living (ALR/CPCH) service package, or the Adult Family Care option

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Medicare Certified Home Health Agency
Individual	Medical Supplier
Individual	Various Approved Vendors

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Licensed Medicare Certified Home Health Agency

Provider Qualifications**License (specify):**

NJAC 8:42

Certificate (specify):

CMS

Other Standard (specify):

May provide supplied up to \$50.

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

Department of Health and Senior Services

Frequency of Verification:

Every two years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Specialized Medical Equipment and Supplies****Provider Category:**

Individual

Provider Type:

Medical Supplier

Provider Qualifications**License (specify):**

N/A

Certificate (specify):

N/A

Other Standard (specify):

NJAC 10:59

Medicaid approved

Provides Fee Schedule

Provides Catalogue/Product Literature

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

Division of Aging and Community Services

State Fiscal Agent

Frequency of Verification:

Provides required evidence of qualifications prior to providing service

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Specialized Medical Equipment and Supplies****Provider Category:**

Individual

Provider Type:

Various Approved Vendors

Provider Qualifications**License (specify):**

As necessary

Certificate (specify):

N/A

Other Standard (specify):

Business Authority (New Jersey Tax Certificate or Trade Name Registration) and Evidence of ownership

Possesses proper business and product insurance, including workman's compensation

Provides Fee schedule

Provides Catalogue/Product Literature

Possesses any license/registration/approval to vend product brands

Signs an agreement with the Division of Aging and Community Services that outlines Specialized medical equipment & Supplies provider responsibilities

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Community Services

Frequency of Verification:

Provides required evidence of qualifications and signs an Agreement with the Department of Health and Senior Services prior to provision of service Initially before providing service to participant

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transitional Care Management

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Services which will assist individuals who are in a nursing facility or sub-acute unit of a hospital or nursing facility to gain access to Waiver services. Transitional Care Management services foster the transition from an institution to a community-based living arrangement.

Transitional Care Management involves the planning, arranging, and authorization of services necessary for the individual to transfer back to the community. Community Transition Services is the actual implementation of a set-up service identified as a need by the Transitional Care Manager and applicant during the planning stage of the relocation.

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

Transitional Care Management may be provided up to six months before the individual leaves the institutional setting. However, Medicaid cannot pay for transitional care management services until after the applicant moves into the community and enrolls in the GO waiver.

Transitional care management (TCM) services are not considered services that a GO participant will receive on a monthly basis. TCM may only be provided in certain circumstances with the purpose of facilitating the transition of a consumer from an institutional setting to the community.

Approved care management agencies may bill for one unit of the waiver service Transitional Care Management, at the designated price, i.e. \$200 for the initial transition/first month of GO enrollment when the Care Manager

has participated in the Interdisciplinary Team meeting. When a GO participant has been admitted to a nursing facility and returns back to the community, the care management agency may bill up to \$285 (3 months x \$95 a month) for up to three months if the Care Manager helped facilitate the transition back to the community, contacted the participant, and worked with the nursing facility staff for interdisciplinary team planning.

The initial fee for Transitional Care Management is billable only if the individual is discharged from the nursing facility/sub-acute unit and enrolled in GO as a new participant.

The Care Manager bills for Transitional Care Management in place of Initial Care Management for the first month of GO enrollment when the Care Manager participated in an IDT.

It is not permissible to bill for both Transitional Care Management and Initial Care Management for the same person.

The fee for Transitional Care Management for the GO participant who is readmitted to the NF is billable for up to three months only if the Care Manager makes the required contacts each month and the person is discharged back to the community.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Accredited Registered Homemaker Agency
Agency	Proprietary or Not-for-profit Care Management entity
Agency	Adult Family Care Sponsor Agency
Agency	Area Agency on Aging
Agency	County Welfare Agency
Agency	Licensed Medicare Certified Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transitional Care Management

Provider Category:

Agency

Provider Type:

Accredited Registered Homemaker Agency

Provider Qualifications

License (*specify*):

NJAC 13:45B-14 (Division of Consumer Affairs)

Certificate (*specify*):

Commission on Accreditation for Home Care Inc. or National Association for Home Care and Hospice or Community Health Accreditation Program or the Joint Commission on Accreditation of Healthcare Organizations

Other Standard (*specify*):

Agency employees must be licensed, Registered Nurses, NJSA 45:11-26 OR licensed or certified

Social Workers, NJSA 45:1-15.
Agency must be Medicaid approved

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

Accrediting Body

Frequency of Verification:

Annually

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Transitional Care Management****Provider Category:**

Agency

Provider Type:

Proprietary or Not-for-profit Care Management entity

Provider Qualifications**License (specify):**

NJSA 45:11-26

NJSA 45:1-15

Certificate (specify):

N/A

Other Standard (specify):

Medicaid approved

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

Division of Aging and Community Services

Frequency of Verification:

Every two years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Transitional Care Management****Provider Category:**

Agency

Provider Type:

Adult Family Care Sponsor Agency

Provider Qualifications**License (specify):**

Licensed per NJSA 26:2Y

Certificate (specify):

N/A

Other Standard (specify):

Care Managers or other Professional Staff designated by the Department complete re-evaluations. Those completing re-evaluations must be licensed, Registered Nurses, NJSA 45:11-26; OR licensed or certified Social Workers, NJSA 45: 1-15; OR have graduated from an accredited college or university with a Bachelor's degree, or higher, in a health related or behavioral science field and have had the following experience: 1,600 hours (46 weeks working 35 hours per week) of paid work or internship experience (non-volunteer) with the elderly or physically disabled in an institutional or community setting.

Agency must be Medicaid approved.

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

Department of Health and Senior Services/Division of Health Facilities and Evaluation

Division of Aging and Community Services

Frequency of Verification:

Every two years

Every two years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Transitional Care Management****Provider Category:**

Agency

Provider Type:

Area Agency on Aging

Provider Qualifications**License (specify):**

45 Code of Federal Regulations 132.1

Certificate (specify):

N/A

Other Standard (specify):

Care Managers or other Professional Staff designated by the Department complete re-evaluations. Those completing re-evaluations must be licensed, Registered Nurses, NJSA 45:11-26; OR licensed or certified Social Workers, NJSA 45: 1-15; OR have graduated from an accredited college or university with a Bachelor's degree, or higher, in a health related or behavioral science field and have had the following experience: 1,600 hours (46 weeks working 35 hours per week) of paid work or internship experience (non-volunteer) with the elderly or physically disabled in an institutional or community setting.

Agency must be Medicaid approved

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

Division of Aging and Community Services

Frequency of Verification:

Annually

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Transitional Care Management****Provider Category:**

Agency

Provider Type:

County Welfare Agency

Provider Qualifications**License (specify):**

N/A

Certificate (specify):

N/A

Other Standard (specify):

Care Managers or other Professional Staff designated by the Department complete re-evaluations. Those completing re-evaluations must be licensed, Registered Nurses, NJSA 45:11-26; OR licensed or certified Social Workers, NJSA 45: 1-15; OR have graduated from an accredited college or university with a Bachelor's degree, or higher, in a health related or behavioral science field and have had the following experience: 1,600 hours (46 weeks working 35 hours per week) of paid work or internship experience (non-volunteer) with the elderly or physically disabled in an institutional or community setting.

Agency must be Medicaid approved
Verification of Provider Qualifications
Entity Responsible for Verification:
 Division of Aging and Community Services
Frequency of Verification:
 Every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transitional Care Management

Provider Category:

Agency

Provider Type:

Licensed Medicare Certified Home Health Agency

Provider Qualifications

License (specify):

NJAC 8:42

Certificate (specify):

CMS

Other Standard (specify):

Agency employees must be licensed, Registered Nurses, NJSA 45:11-26 OR licensed or certified Social Workers, NJSA 45:1-15.

Agency must be Medicaid approved

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Senior Services

Division of Aging and Community Services

Frequency of Verification:

Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transportation

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Service offered in order to enable individuals served on the Waiver to gain access to Waiver and other community services, activities and resources specified in the Plan of Care. This service is offered in addition to medical transportation required under 42 Code of Federal Regulations 431.53 and transportation services under the State plan, defined at 42 Code of Federal Regulations 440.170(a) (if applicable), and shall not replace them. Transportation services under the Waiver shall be offered in accordance with the individual's Plan of Care. Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge will be utilized. Transportation as a Waiver service is one that enhances the individual's quality of life. An approved provider may transport the participant to shopping, to the beauty salon, the bank, or to the religious services of his or her choice.

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

Services are limited to those that are required for implementation of the Plan of Care.

Transportation incidental to the provision of another service is not reimbursable.

Reimbursement for private vehicles will be set at the State rate of mileage reimbursement.

When available, appropriate to the participant's need and capabilities, and cost-effective, transportation shall also mean the use of public transit, tickets, etc.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Family Care Caregiver or substitute caregiver
Individual	Participant Employed Provider (PEP)
Agency	Transportation Provider Registered as a Business in NJ

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Adult Family Care Caregiver or substitute caregiver

Provider Qualifications

License (specify):

All Caregivers/Substitute Caregivers must possess a driver's license that is valid in New Jersey.

Certificate (specify):

N/A

Other Standard (specify):

Vehicle must be maintained in proper operating condition and must meet the requirements of New Jersey regulations, as evidenced by a valid inspection sticker.

Owner must have proof of liability insurance coverage for the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

Care Manager

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transportation

Provider Category:

Individual

Provider Type:

Participant Employed Provider (PEP)

Provider Qualifications

License (specify):

All operators must possess a driver's license that is valid in New Jersey

Certificate (specify):

N/A

Other Standard (specify):

Vehicle must be maintained in proper operating condition and must meet the requirements of New Jersey regulations, as evidenced by a valid inspection sticker.

Owner must have proof of liability insurance coverage for the vehicle.

Participant-Employed Provider must meet all initial qualifications as a Participant-Employed Provider before being considered as a Transportation Provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant/Care Manager

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transportation

Provider Category:

Agency

Provider Type:

Transportation Provider Registered as a Business in NJ

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

Provides required evidence of Insurance, i.e. Declaration Page from Insurance Company

Provides Description of vehicles used in service and copies of any required licenses

Vehicle appropriately registered, inspected and insured. Driver licensed to operate the vehicle

Provides proof of New Jersey Business Authority, i.e. tax certificate or trade name registration

Provides Fee Schedule

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Aging and Community Services
Frequency of Verification:
 Prior to providing Service

Appendix C: Participant Services

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

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

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

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

Check each that applies:

- As a waiver service defined in Appendix C-3. Do not complete item C-1-c.**
- As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.**
- As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.**
- As an administrative activity. Complete item C-1-c.**

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

N/A

Appendix C: Participant Services

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

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

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

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

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

Sagem Morpho, an internationally recognized leader in multi-biometric solutions including fingerprint processing, performs State/Federal Criminal background checks under the auspices of the New Jersey Department of Law and Public Safety, Division of Consumer Affairs for Registered Nurses, Certified Home Health Aides/Homemakers, Certified Nursing Assistants, Assisted Living Administrators, and Adult Family Care Caregivers and all non-participant residents age 18 and older in the Caregiver's home. Both Federal and State databases are used in the background check process. Copies of mandatory investigations involving health care professionals servicing Waiver participants are available to CMS upon request.

New Jersey Statutes Annotated (N.J.S.A.) 45:1-30 et seq. requires a criminal history background check for every person who possesses a license or certificate as a health care professional. Registered Nurse Care Managers, Certified Home Health Aides/Homemakers, Certified Nursing Assistants (Assisted Living), and Assisted Living Administrators are in this category. The State agency, the Department of Health and Senior Services Division of

Health Facilities Evaluation and Licensure or the New Jersey Board of Nursing, ensures that mandatory criminal investigations have been conducted for each individual applying for licensing, certification, and renewals.

Any Medicaid home care or institutional provider is responsible for assuring its accrediting/licensing body that all employees have been fingerprinted and criminal background checks have been completed. Proof of criminal background investigations is reviewed in personnel files when Health Facilities Evaluation and Licensure surveys Nursing Facilities, Assisted Living Facilities, Adult Family Care Sponsor Agencies, and licensed, certified, Home Health Agencies. Independent credentialing organizations contracting with the State to survey certified Homemaker Agencies do the same for them.

N.J.S.A.45:15BB and N.J.A.C. 13:44G require a criminal history background check for every person who possesses a license or certificate as a Social Worker. Copies of the statute are available upon request from the Division of Aging and Community Services.

Care Managers who are not Registered Nurses or Licensed/Certified Social Workers, but who otherwise meet Care Manager provider standards and work for an approved care management agency, are not required by the State to have a criminal history and/or background investigation, but may be required to have such by their county or private employers.

Electronic State and Federal Criminal Background Investigations are required for every Adult Family Care Caregiver, Substitute Caregiver, and all non-participant residents of the home age 18 and older prior to providing care and shelter to an Adult Family Care participant. Tracking of the fingerprints is ongoing.

A Home-Based Supportive Care Agency, licensed as a Health Care Service Firm, Employment or Temporary Agency must provide documentation that employees have undergone criminal background checks as a qualification to provide services to a participant in his or her home.

An individual Participant-Employed Provider, a provider type for Home-Based Supportive Care, must complete an electronic State and Federal criminal background check prior to providing service to any Waiver participant. Tracking is ongoing and fingerprints are submitted for Federal check every two years.

No criminal history and/or background investigation is required for employees of Social Adult Day Care providers unless they are in one of the professional categories identified above.

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

No. The State does not conduct abuse registry screening.

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

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

Promissor is the vendor contracted by the New Jersey Department of Health and Senior Services to maintain the Nurse Aide registry. If a Nurse Aide is found to have committed an act of abuse, neglect or misappropriation, a finding of that is placed along side his or her name in the registry. Promissor renews the Nursing Assistant's certification every two years after the:

- State updates the criminal history;
- Certified Nursing Assistant produces documentation that he or she has worked for at least seven hours in long-term care during the required timeframe; and
- Certified Nursing Assistant has no abuse, neglect or misappropriation of residents' property placed on his or her Nursing Assistant registry entry.

Promissor, on behalf of the State, denies recertification if the individual does not meet the above criteria. Certified Nursing Assistants work in nursing facilities (Respite providers) and also in Assisted Living Facilities.

While the New Jersey Board of Nursing does not keep an abuse registry, per se, for Registered Nurses, Licensed Practical Nurses, or Certified Homemaker/Home Health Aides, it does have an equivalent check through its

disciplinary process. All complaints, criminal and non-criminal, about a Registered Nurse or Licensed Practical Nurse are investigated by the Board. A decision is made regarding grounds for disciplinary actions and resolution. The resolution, a Public Order, is accessible on the Board's on-line licensing website by keying in the individual's name. The website is updated monthly. There is a flagging mechanism in the system, which notifies the Board of Nursing if a Registered Nurse or Licensed Practical Nurse has been indicted or convicted of a crime since the license was issued. If this occurs, the Board makes a determination whether to impose restrictions on the license or to deny the license. The outcome of this process is also available on the website.

Certified Homemaker Home Health Aides (CHHHA) are overseen by a unit within the Board of Nursing that is different from the one that deals with the licenses of Registered Nurses and Licensed Practical Nurses. Certified Homemaker Home Health Aides are required to have a criminal background check as a condition of certification. Fingerprints are taken initially for a Federal and State background check and resubmitted every two years for a Federal check. The State has an ongoing criminal background investigation. N.J.S.A. 45:11-24.3 lists the crimes that would disqualify an individual from certification. If an aide is disqualified or disciplined, the information is available on the Board's website. Registered Nurses, licensed practical nurses, and Certified Homemaker Home Health Aides, are also required to self-report any indictments or convictions. The Board accesses its files and website before issuing/reissuing a license or certification for those health care providers under its jurisdiction.

Appendix C: Participant Services

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

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

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

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

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

Facility Type	
Nursing Facility	

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

N.J.A.C. 8:85-2.5 and 2.6 address such issues as resident activities and programs, use of outside community resources, resident activity Staff requirements, activity scheduling requirements and space and equipment requirements as well as social services to enhance a resident's sense of well-being and control over his life to the fullest extent possible. N.J.A.C 8:85-2.19 requires housekeeping and maintenance services necessary to maintain a sanitary and comfortable environment. N.J.A.C. 8:39, Licensure of Long-Term Care Facilities addresses all of the standards identified in the Scope of Facility Standards section under the Nursing Facility provider type above.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Nursing Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Respite	<input checked="" type="checkbox"/>
Chore Services	<input type="checkbox"/>
Social Adult Day Care	<input type="checkbox"/>
Adult Family Care	<input type="checkbox"/>
Care Management	<input type="checkbox"/>
Personal Emergency Response System (PERS)	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>
Transitional Care Management	<input type="checkbox"/>
Environmental Accessibility Adaptations (EAA)	<input type="checkbox"/>
Home-Delivered Meals	<input type="checkbox"/>
Assisted Living Program (ALP) in Subsidized Housing	<input type="checkbox"/>
Home-Based Supportive Care	<input type="checkbox"/>
Attendant Care	<input type="checkbox"/>
Assisted Living (ALR or CPCH)	<input type="checkbox"/>
Caregiver Participant Training	<input type="checkbox"/>
Transportation	<input type="checkbox"/>
Community Transition Services	<input type="checkbox"/>

Facility Capacity Limit:

No generic limit. # of licensed beds determines # of people served at any time. # of beds depends on the # of units that can be created per regulations for room size and overall square footage.

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input type="checkbox"/>

	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

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

N/A

Appendix C: Participant Services

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

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

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

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

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

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

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

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

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

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is

qualified to provide services as specified in Appendix C-1/C-3.

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

Relatives, but not legal guardians or legally responsible relatives, may be paid for providing Home-Based Supportive Care, Chore Service, Attendant Care, or Transportation services to participants. Once a relative is approved to provide services, the Care Manager completes an Individual Service Agreement (ISA) on the Home and Community-Based Services website, authorizing the worker, type of service, frequency, units, and rates. The relative, known as a Participant-Employed Provider, submits time sheets, signed by the participant, to the Fiscal Intermediary, as the invoice for payment. The Fiscal Intermediary compares the timesheets with the Individual Service Agreement and reimburses when all criteria for payment match. If there are questions, the claim is pended until issues are resolved.

Other policy.

Specify:

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

Any willing and qualified provider is welcome and recruited.

The Department of Human Services, Division of Medical Assistance and Health Services' (DMAHS) Internet home page maintains an easily accessible Provider Relations website. The website contains a Provider Enrollment Application, Provider Registry, a list of Provider Services, Provider Directory and Site Requirements for the Provider. Provider Relations, through UNISYS, provides Comprehensive Training for the Provider Community to educate and update providers on current billing procedures, problems, and claims processing. These trainings are held at UNISYS, at the Provider's place of business, or in regional locations.

In addition, the Division of Health Facilities Evaluation and Licensure, Department of Health and Senior Services, includes a Medicaid Provider Enrollment Office that responds to inquiries from applicants interested in becoming Medicaid providers of Care Management, Social Adult Day Care, Respite, Adult Family Care, Assisted Living Program, and Assisted Living and processes applications for the same.

The Office of the Assistant Commissioner' Quality Management Staff responds regularly to questions from prospective Waiver providers, explaining the qualifications of providers, responsibilities towards participants, and application process. The Division of Aging and Community Services Unit of Data Management processes all applications for non-traditional providers of Waiver services. Staff responds to requests for an application to provide a specific service, reviews applications for all required documentation to provide a specific service, and processes the agreement when all criteria are met. Staff maintains all Provider files for these providers.

Counties are encouraged to contact non-traditional providers for all services, but especially Community Transition Services, Environmental Accessibility Adaptations, Home-Based Supportive Care, and Home-Delivered Meals because local entities are more apt to deliver services to those in close proximity.

The time frame for approving a prospective provider is approximately one month from the submission of the Medicaid provider enrollment application if the applicant provides all necessary information, i.e. proof of license, accreditation, with the application and it is completed correctly.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

- a. **Methods for Discovery: Qualified Providers**
i. **Sub-Assurances:**

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Prior to enrollment as a Traditional Medicaid provider, the number and percent of new provider applications that the State Fiscal Agent verifies to meet the provider enrollment requirements (licensure, certification) that were developed by DHSS' DACS.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider enrollment approval notifications issued by the State Fiscal Agent.

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

Number and percent of all qualified, approved Care Management Agencies that are monitored every two years to assure adherence to GO Waiver requirements.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Record Review

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

	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

Performance Measure:

Number and percent of all Assisted Living and Adult Family Care (AL/AFC) providers that the State Division of Health Facilities Evaluation and Licensing monitors through routine biennial licensing visits.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HFEL letters to AL/AFC providers ordering Plan of Correction, applicable Statements of Deficiencies, and/or imposing Monetary Penalties as a result of Licensure Violations.

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

<input checked="" type="checkbox"/> Other Specify: Health Facilities Evaluation and Licensing	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: []
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: []
	<input type="checkbox"/> Other Specify: []	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: []	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Prior to approval, number and percent of applicants who apply to provide services of a Non-Traditional nature (e.g. Meals-on-Wheels, PERS, Environmental Accessibility Adaptations) that complete the NJDHSS Provider Application which requires the inclusion of proof of licensure/certification and/or compliance with

other standards established for the individual service.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Signed Application and Approved Provider Agreement/Contract; Provider database

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually

	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:
 Prior to approval as a Participant-Employed Provider, number and percent of all provider applicants have passed a State and Federal criminal background investigation.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Notification from DHSS Criminal Investigation Unit; PEP Database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input checked="" type="checkbox"/> Other Specify: DHSS Criminal Investigation Unit	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHSS Criminal Investigation Unit	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

Number and percent of participant records that include the following documents when a Participant Employed Provider is utilized: An Individual Service Agreement signed by the participant; an Employment Application; the Certification of Qualifications; the PEP Handbook and the Employer Guide as given to the participant.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Record Review Off-site

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from each Care Manager, opened during past 3years, calculating sample size with Conf Intvl of 5; Confidence Level of 95%; Pop Size:# of Enrolled participants;

		Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Number and percent of time DACS provides biennial core training to existing care management agencies for professional skills development.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Copies of the Core Care Management Training series, a list of annual Training Schedules and Attendees, and a Catalog of specialized presentations available through DACS.

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of time DACS provides biennial three-day training for new care management agency applicants statewide to review and train on program policies and operational procedures.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Training Notice, Agenda and Attendee lists are maintained on file by the DACS Quality Assurance Unit.

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually

<input checked="" type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

Number and percent of time DACS provides at least annual all-day, in-depth training to approved Assisted Living providers.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:
 Number and percent of time DACS provides quarterly meetings for the Supervisors of approved care management agencies statewide to train them on policy and program operational procedures as well as quality assurance oversight.

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

Number and percent of time DACS provides biannual regional meetings for Care Managers to train on policy and program operational procedures as well as quality assurance oversight.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Meeting Agendas and Attendee lists are maintained on file by the DACS Quality Assurance Unit.

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

<input checked="" type="checkbox"/> Other Specify: Twice a year		

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

There are three types of Providers: 1)Traditional Provider: an individual or entity provider who provides authorized services to a participant and who is enrolled as an approved Medicaid provider able to bill the State Fiscal Agent directly for the authorized service,2)Non-Traditional Provider: An individual or entity that is not enrolled to bill the State Fiscal Agent directly for services but who demonstrates competence to qualify as a provider of services pursuant to the approved Medicaid waiver criteria and provides authorized services to a participant,3)Participant-Employed Provider: An individual provider/worker who provides authorized services as an employee of the participant. Traditional Providers: The State’s fiscal agent is also charged with enrolling Traditional Waiver Service Providers, such as Care Managers, Respite Agencies/Nursing Facilities, Adult Family Care Sponsor Agencies, Assisted Living Residences, Comprehensive Personal Care Homes, Assisted Living Program providers, Home-Based Supportive Care, and Social Adult Day Care Agencies in the Medicaid System. All Waiver service providers in this category are licensed, certified, accredited, or otherwise approved annually or periodically to provide services. In addition, the mission of the Department of Health and Senior Services’ Division of Health Facilities Evaluation and Licensing (HFEL) is to ensure that New Jersey citizens receive quality health care at appropriate levels of care in regulated facilities. To accomplish that, this Division: Regulates a wide range of health care settings for quality of care, such as hospitals, nursing homes, assisted living residences, ambulatory care centers, home health care, medical day care and others; Investigates complaints received from consumers and other state/federal agencies; Licenses Nursing Home and certifies Assisted Living Administrators; Certifies Nurse Aides, including performing background checks; Provides consumer information via report cards and other performance information. To ensure that New Jersey citizens receive quality health care, this Division: Licenses more than thirty types of health facilities and services; Develops new licensing standards and revise existing standards as necessary; Accepts and evaluates certificate of need applications; Inspects facilities for compliance with state and federal regulations; Investigates all complaints and review all adverse events reported by facility staff; Enforces state licensing regulations and Medicare certification standards; Licenses Nursing Facility Administrators and

certify Assisted Living Administrators; Certifies Nurse Aides and manages the Certified Medication Aide Program; Conducts training programs for the regulated industry and personnel. Furthermore, the Division operates a 24-hour Complaint Hot Line to handle consumer complaints and facility emergencies 7 days per week. Specific to the GO program, HFEL directly promotes the provision of quality health services through the enforcement of state licensing regulations and Medicare certification standards. All providers of Assisted Living/Adult Family Care services are required to be licensed by HFEL. When personal care services are rendered to participants who reside in a private home in the community, as opposed to a licensed setting, there are private agencies that are approved to render such home care services. For example, a Home-Based Supportive Care agency that wishes to provide personal care (Assistance with ADLs) must be a Home Health Agency or licensed as a Health Care Service Firm. Only Certified Homemaker Home Health Aides, working under the supervision of a Registered Nurse, may provide such personal care. The approved provider must submit a copy of their license or certification renewal on an ongoing basis according to the licensing/certification renewal schedule. Certification as a Homemaker Home Health Aide is provided through the following entities: Accreditation by National Home Caring Council; Commission on Accreditation for Home Care Inc.; Community Health Accreditation Program; or the Joint Commission on Accreditation of Healthcare Organizations. A Health Care Service Firm (HCSF) license is issued through the NJ Department of Law and Public Safety/Office of the Attorney General. The Office of the Attorney General's (OAL) Division of Consumer Affairs, through its Regulated Business Section, registers and oversees all Health Care Service Firms. An online registry lists the Health Care Service Firms which also includes the expiration date of the Health Care Service Firm's license. Non-Traditional Providers: If a provider applicant is a "Non-Traditional" provider, e.g. Meals-on-Wheels, PERS, Environmental Accessibility Adaptations, etc., a responsible party must complete a six-page application. The applicant must also complete the following forms: Certification Regarding Debarment and Suspension form, Ownership Disclosure Form, and W-9 Questionnaire. Non-Traditional providers also sign an agreement with DHSS agreeing to all terms required for the delivery of a specific service, prior to the delivery of the service. The monitoring of providers of non-traditional services is done prospectively prior to approval for program participation. Each applicant that wishes to provide services of a non-traditional nature must complete the above-mentioned application which requires the inclusion of proof of compliance with standards established for the service. For those Waiver service providers that are considered "Non-Traditional", it has been practice to verify ongoing conformance with the established standards by: Checking provider qualifications in response to questions raised by Care Managers or the public; Requiring proof of new licensure when a provider notifies MIS & DM of a change in ownership; and Relying in part on the knowledge that other State or county agencies have authority and or contracts/agreements with mutual providers.

b. Methods for Remediation/Fixing Individual Problems

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

As needed by Medicaid providers for initially training or refresher sessions, the State Fiscal Agent's Customer Education Team regularly offers a suite of state-of-the-art trainings, in a variety of delivery formats, which afford providers the opportunity to maximize their productivity. Through the State's Medicaid provider (www.njmms.com), the New Jersey Department of Human Services' Division of Medical Assistance and Health Services distributes Provider Newsletters and Alerts regarding important contract information as well as State Fiscal Agent provider training updates and training schedules. With Client Site Training, courses can be scheduled on a date that is convenient for providers, and because they can be scheduled on location, providers don't incur travel costs.

Also, in general, the New Jersey Office of Administrative Law' Division of Consumer Affairs protects the public from fraud, deceit and misrepresentation in the sale of goods and services. Among its other responsibilities, the NJ Division of Consumer Affairs (DCA) supervises the activities of 41 boards and committees, regulating more than 80 professions and occupations. Approximately 600,000 New Jerseyans are licensed by these boards.

When DACS receives notification from the State Fiscal Agent (Molina Health Care), one of the Accrediting bodies, the DHSS Division of Health Facility Evaluation and Licensing, a Care Management site or another agency, that there is a closing or substantiated complaint against a provider, then the Operating Agency would notify the Care Management agencies in that service coverage area. If the provider complaint is substantiated and the agency loses its status as an approved provider then services would be terminated and the Care Management agency would arrange for services to be provided to the participant by another qualified provider of the service as well as honoring the participant's choice.

- ii. **Remediation Data Aggregation**

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: _____	<input type="checkbox"/> Annually
<input checked="" type="checkbox"/> Continuously and Ongoing	
<input type="checkbox"/> Other Specify: _____	

c. Timelines

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

No

Yes

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

Social Adult Day Care:

Although Social Adult Day Care (SADC) providers are also considered Traditional, Medicaid enrolled providers, available to render services to Global Options participants, presently SADC centers are not required to be licensed or certified, and there is not one State agency that is charged with executing on-site surveying of these providers. However, the SADC center must meet all local building code requirements and adhere to provider qualifications and standards as identified in the Medicaid Waiver application. SADC is a community-based group program designed to meet the needs of adults with functional impairments through an individualized plan of care. It offers a structured comprehensive program that provides a variety of health, social and related support services in a protective setting during any part of a day but less than 24-hour care. The Care Manager makes authorization for SADC as part of the Plan of Care. Only Medicaid-enrolled SADC providers are reimbursed. The day care provider directly bills Medicaid for per diem services. SADCs which receive funding through the Area Agency on Aging or the state-funded Alzheimer's Adult Day Services program are surveyed on-site periodically by the administering bodies of those programs.

For Global Options Medicaid Waiver participants, DACS is currently developing a Survey Tool based upon a tool used by the state-funded Alzheimer's Adult Day Services program for monitoring SADC. The tool will be modified to incorporate any Medicaid Waiver requirements, and a portion of the tool will be developed as a self-assessment/screening device for SADC on which to obtain a base line of information. When applying to become an approved Medicaid Waiver provider all SADC will be required to consult with the DACS Quality Assurance Unit to ensure an appropriate understanding of GO program policies and procedures.

Milestone: The SADC tool is to be finalized in the Fall of 2011. DACS will begin to preliminarily reassess the provider qualifications of the approved SADC centers based on information that is gathered from the administering bodies of all DACS programs that cover SADC services between December 2011 and April 2012. SADC centers that have been identified as not having had an on-site review or that warrant an on-site visit by DACS staff will be monitored in Summer 2012 for follow-up. Any reports from SADC monitoring will become a regular part of the overall DACS Quality Management and Improvement Strategy.

Provider Agreement:

The State assures prospectively that provider applicants meet all criteria/standards for delivering a specific service through the application process, which requires documentation that the applicant meets the standards and

an agreement signed by the applicant and Assistant Commissioner confirming eligibility to provide services.

Ultimately, all Providers must provide evidence that all criteria requirements are met and sign a Provider Agreement with the State Department of Health and Senior Services prior to rendering services to any participant.

DHSS and DMAHS met to discuss the Provider Agreements that the Division of Aging and Community Services currently used to enroll non-traditional providers. Both Divisions agreed to add a section in the agreement regarding 'Termination as a Provider' and to otherwise strengthen the agreement to reflect the confirmation of ongoing compliance with applicable requirements.

Milestone: The Provider Agreement is currently under review by staff from DACS. By Fall 2011 it will be finalized. It will be revised as necessary to include requirements for the provider to give proof on a periodic basis that it continues to meet the qualifications and standards for the service. The revised Agreement will be sent to all newly enrolled providers as well as current providers for continued program participation by January 1, 2012, by the DACS Data Management Unit. Any providers that do not sign the updated Provider Agreement will no longer be approved providers in the DACS Database.

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

- Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*

Prior to the approval of the Global Options for Long-Term Care Medicaid Waiver on January 1, 2009, the NJ Department of Health and Senior Services operated three separate 1915(c) Waivers -- the Community Care Program for the Elderly and Disabled Waiver, the Assisted Living Waiver, and the Enhanced Community Options Waiver. The Community Care Program for the Elderly and Disabled (CCPED) Medicaid Waiver was first approved in 1983. In CCPED two monthly service caps were established to control the spending for services for participants. The caps were predicated on the average monthly cost of nursing home placement, which was \$2,841. 80% of the participants were eligible for a 70% slot, with a monthly cap of \$1,989 and 20% of the participants could qualify for a 100% slot of \$2,841. The caps were inclusive of all services billed to Medicaid, both the limited State Plan package (Home Health, Non-emergency Transportation, Adult Day Health Services and Prescription Drugs) as well as the four Waiver Services: Care Management, Homemaker, Respite, and Social Adult Day Care. Persons previously enrolled in the Caregiver Assistance Program component of the Enhanced Community Options Waiver, had a spending cap of \$1,100 a month for Waiver Services. They also had access to all State Plan Services for which they qualified. Individuals previously enrolled in Assisted Living/Assisted Living Program/or Adult Family Care had a service package that was reimbursed at an all-inclusive per diem rate. Those participants also had access to Special Medical Equipment in all three settings; Personal Emergency Response System in Assisted Living Program and Adult Family Care, and Environmental Accessibility Adaptations in Adult Family Care.

When it was decided to consolidate the three Waivers into the Global Options for Long-Term Care (GO) Waiver, it was determined that, based on an analysis of the 372 reports, additional monthly reports from the State's Fiscal Agent's data warehouse, and historical usage of services, it was reasonable to keep the spending cost cap of up to \$2,841 a month for all GO participants, which was the maximum cap permitted in the former CCPED Waiver. GO participants continue to have access to all State Plan Services for which they are qualified, which may include Personal Care Assistant and Adult Day Health Services. The extent to which state plan services are received, as prior authorized by his or her Managed Care Organization, is considered by the Waiver Care Manager in GO Plan of Care development so as to avoid service duplication in the arrangement and receipt of home and community-based long-term care for GO participants.

Parameters of the GO program, including the cost cap and service limitations, were established and continue to be upheld to ensure that the Waiver is managed in a manner that promotes the cost-effective delivery of home and community-based services. The use of required forms such as the comprehensive assessment/level of care evaluation, needs based care allocation tool, special request authorizations, individual service agreements, service cost records, and the Plans of Care, all contribute to efficient utilization oversight and strive to link the delivery of waiver services to other state and local programs and their associated service delivery systems.

For all participants, before Plan of Care development, the Care Manager reviews the initial Comprehensive Evaluation completed by the Office of Community Choice Options Staff or Professional Staff designated by the Department. The individual's Comprehensive Evaluation used to determine nursing facility level of care is also used in developing the Plan of Care. All services authorized by the Care Manager, which are identified in the participants Plan of Care, are based on the individual's assessed needs. Waiver services are arranged to complement and/or supplement (not replace) the services that are already available to participants through the Medicaid State Plan and other federal, state and local public programs as well as the supports that families and communities provide. The GO program is not intended to off-set the cost of agencies paid for privately by other parties. Upon enrollment, a comprehensive Plan of Care is developed by the GO participant and his or her Care Manager. A need based care allocation tool is utilized as a consistent and objective means of assisting Care Managers (CM) in determining the hours of home and community based services a GO participant requires. The need based care allocation tool is used to assist

Care Managers in determining a GO participant's care needs when developing the initial Plan of Care, the annual Plan of Care or when there has been a significant change in the participant's functional abilities or a significant change in caregiver status requiring a revision to the Plan of Care. GO participants are provided services based on the information recorded on the comprehensive evaluation and the need based care allocation tool while also considering the professional judgment of the Care Manager in determining hours of service. The need based care allocation tool is used in conjunction with the following documents, as applicable: initial Comprehensive Evaluation and Interim Plan of Care, Plan of Care (WPA-2), and the LTC Re-Evaluation (WPA-1) when completed as required.

Plans of Care are developed based on assessed needs. Services are arranged according to the person's need and availability of services and choice of approved providers. As needed, a participant may receive up to 40 hours of Home-Based Supportive Care each week or opt to receive the State Plan Personal Care Assistant service (PCA) as prior authorized by the applicable Managed Care Organization. If an increase in state plan PCA hours or ADHS attendance is warranted the Managed Care is responsible. If services to meet a participant's care needs are assessed to exceed \$2,841 a month, the Care Manager will review the exception with his or her CM Supervisor. When the CM Supervisor confirms the need, the request will be submitted to the designated DACS staff with a copy of the initial/re-evaluation, Plan of Care, written justification for the increase, and projected cost of additional services for approval and implementation (which may include additional hours of Home-Based Supportive Care while remaining mutually exclusive from PCA which will not be authorized unless the participant opts for PCA instead of HBSC). The most common reasons for an increase are because of a change in the participant's condition or a change in his or her informal supports. When either situation occurs, it may be necessary to increase services to safeguard the health and welfare of the Waiver participant. Since the Waiver is managed in the aggregate to assure cost-neutrality, and the exact services/spending limits of each participant varies according to assessed needs, the Waiver can accommodate those whose needs will exceed the spending cap. If a participant's care needs can no longer be met under the Global Options for Long-Term Care Waiver and the individual's well being is a concern, other options, including institutionalization, would be discussed.

Individuals are notified of the GO program spending limits through program literature, Department website, counseling when home and community-based service alternatives are discussed vis-à-vis institutionalization at the time of the initial evaluation, during the Interdisciplinary Team meeting in a Nursing Facility when an individual is relocating to the community, and in discussions with the Care Manager as the Plan of Care is being developed.

The reimbursement for the Waiver Services of Assisted Living, Assisted Living Program, and Adult Family Care remains the same. The needs based care allocation is not utilized for GO participants in AL, ALP or AFC settings. Reimbursement to AL, ALP and AFC providers is based on a per diem rate for services provided to participants, approved by the Office of Management and Budget and State Legislature.

Any changes in the methodology or the rates for the monthly monetary caps must be passed by the Legislature and published in the New Jersey Register for public review and comment. The public can also request this information under the Open Public Records Act process.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Plan of Care

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

- Registered nurse, licensed to practice in the State**
- Licensed practical or vocational nurse, acting within the scope of practice under State law**
- Licensed physician (M.D. or D.O)**
- Case Manager (qualifications specified in Appendix C-1/C-3)**
- Case Manager (qualifications not specified in Appendix C-1/C-3).**

Specify qualifications:

Social Worker.
Specify qualifications:

Other
Specify the individuals and their qualifications:

Per NJAC 8:36-7.1 and 7.2, each individual admitted to an Assisted Living (AL) Facility or Assisted Living Program receives an initial evaluation by the AL facility's Registered Nurse to determine the resident's needs. If this initial evaluation indicates the resident has general service needs, a General Service Plan shall be developed by the AL facility's Registered Nurse or certified Assisted Living Administrator within 14 days of the individual's admission. If the initial evaluation indicates that the resident requires health care services, a health care evaluation shall be completed within 14 days of admission by the AL Registered Nurse using an evaluation instrument available from the Department of Health and Senior Services, or an evaluation instrument that has been adopted by the AL facility or program. Based on the health care evaluation, a written health service plan shall be developed. The initial health care evaluation shall be documented by the AL Registered Nurse and shall be updated as required, in accordance with NJ I:36 and professional standards of practice.

In Adult Family Care, the Sponsor Agency's Registered Nurse, Social Worker, or qualified Care Manager is responsible to develop the Plan of Care.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

At present, the DACS Office of the Assistant Commissioner, Quality Assurance Unit has the following procedures in place to mitigate the influence the provider has on the service plan development:

1. The procedures for developing the Plan of Care include a section called Participant's Choices, that State: "If the Care Management Agency provides other direct services to the participant, that agency must establish safeguards to document that Plan of Care development is conducted in the best interests of the participant and avoids the conflict of interest problems that could arise in this circumstance. These safeguards must include full disclosure to participants and assurances that participants are supported in exercising their right to free choice of providers and are provided information about the full range of Waiver services and providers, not just the services furnished by the Care Management Agency."

2. Ways in which conflicts are eliminated and the participant is notified of available providers include 1) giving the participant a list of providers at the initial visit and discussing various providers with them; 2) providing participant with list of approved providers and asking participant to select providers according to his or her preference; 3) continuing education provided on visits or phone calls offering participants choices; and 4) notifying participant at the first visit, verbally and in writing, of all services available, and verbal repeats at least annually. The Care Manager advises the participant that services can be started, cancelled, renewed, or modified at the participant's request.

3. At the time of the DACS Quality Assurance Unit's Survey, participant files are reviewed to ensure that the participant had choice in services and providers.

4. During the DACS Quality Assurance Unit's Survey, participants are interviewed to ensure that they had choice in services and providers and participated in the development of the Plan of Care. Any conflicts are addressed with the Care Management agency. Participant Satisfaction Surveys are completed through the mail as well to gather related information directly from participants and/or their family.

5. The DACS Quality Assurance Unit can determine the services, providers and Care Management agency of participants from New Jersey Medicaid Management Information System (MMIS) reports. The DACS Office of the Assistant Commissioner and the Data Management Unit can request reports from SURS unit of MMIS to identify the Care Management Sites that are also billing for other Waiver/State plan services to check on frequency and amount. If it appears that the majority of the participant's services are provided by the Care Management Site, the Site will be contacted by the DACS Quality Assurance Unit to question/discuss and correct as necessary.

In April 2010, the then Office of Global Options for Long-Term Care and Quality Management sent a GO Conflict of Interest/Self-Referral Survey to the six care management agencies that could provide other direct Waiver services to GO participants. All six agencies returned completed surveys. In total, those six sites care manage 1,497 participants.

Of particular interest was how many individuals received either Personal Care Assistant services or Home-based supportive care services from any provider agency and of that number, how many received Personal Care Assist services or Home-Based Supportive Care services from the care management agency. In total, 2 GO participants received Personal Care Assistant services and 1,294 participants received Home-Based Supportive Care services; none of those individuals received the Personal Care Assistant services from the care management agency and 53 of the 1,294 participants or (4.1%) received the Home-Based Supportive Care services from the care management agency. Ways in which the participant is notified of available providers include: 1) giving the participant a list of providers at the initial visit and discussing various providers with them; 2) providing participant with a list of local providers and asking participant to select providers according to his or her preference; 3) continued counseling provided during visits or phone calls offering participants choices; and 4) notifying participant at the first visit, verbally and in writing, of all services available, and verbal repeats. The Care Manager advises the participant that service delivery can be cancelled or modified at the participant's request. Based on the survey responses, the Division of Aging and Community Services found that there was no issue with any of the Care Management Agencies regarding conflict of interest.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

All participants are given the GO Participant Handbook and Enrollment Agreement at the initial home visit conducted by the Care Manager upon Waiver enrollment. The Handbook discusses the nature of the program, Care Management services, developing the Plan of Care, Waiver Services available, opportunity to file for a fair hearing, and other important information (such as the phone number of his or her Care Manger, service providers, Adult Protective Services, and other emergency contacts). In the Handbook, the participant is made aware of the opportunities that exist to self-direct his or her care and his or her choice to determine who can be included in the care planning process.

A Plan of Care policy was originally distributed in September 2007 and then revised and updated in 2011. This Policy and Procedure outlines specifically the available supports and information for the participant in developing a Plan of Care. The Plan of Care Policy and Procedures instruct Care Managers to determine to what degree the participant desires to participate in the Plan of Care process and to develop the Plan of Care with the participant's representative/legal representative if the participant requests their presence and involvement.

The Plan of Care form (WPA-2) includes a section where the participant and/or his or her representative/legal representative complete check-off boxes and sign to indicate that they 1) agree with the Plan of Care; 2) had the freedom to choose the services in the Plan of Care; 3) had the freedom to choose the providers of their services based on available providers; 4) helped develop the Plan of Care; 5) are aware of their rights & responsibilities as a participant of the program; 6) aware that the services are not guaranteed; 7) have been advised of the potential risk factors outlined in the Plan of Care; and 8) understand and accept the potential risk factors. The participant and his or

her representative/legal representative are also informed of the costs of the services (see Appendix I-2-a), and are given the supports necessary to actively engage and direct the Plan of Care development. The participant signs the Plan of Care to indicate he/she agrees with the service plan and is given a copy signed by participant, participant's representative/legal representative, Care Manager, and Care Manager's Supervisor.

The NJ MMIS website maintains a provider database for all approved providers statewide in the form of a Provider Directory. This Directory options allows users, such as Care Managers, to search for potential providers for GO participants by County, by Provider Type, by Provider Specialty, or by Provider name. The search results give the user information about the Provider, such as its address, its phone number, its email, its specialties, and whether or not its status is open to accept new consumers. In addition, the DACS Quality Assurance Unit also transmits a copy of any newly approved provider's Medicaid enrollment letter to the Care Management sites in the county wherein the provider is expected to deliver services for easy access to new information.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

A Plan of Care policy was originally distributed in September 2007 and then revised and updated in 2011. This Policy and Procedure fully addresses the standards established for all participant-centered service plans.

a) The Plan of Care is developed by the participant (to the degree desired), his or her representative/legal representative (as requested by the participant) and the Care Manager. A fully developed Plan of Care must be finalized and signed by the participant, his or her representative/legal representative, Care Manager, and Care Manager's Supervisor within 30 days of the Care Manager's having received the case file. It is permissible to use the Service Authorization/Interim Plan of Care, which is developed as part of the Comprehensive Evaluation/Pre-Admission Screen, as the interim plan to initiate services before the development of a full Plan of Care (WPA-2). For those individuals who are discharged from a nursing facility to Global Options for Long-Term Care, an Interdisciplinary Team, directed by the applicant (as much as he or she desires or is capable of) and including his or her representative/legal representative, Community Choice Counselor, Nursing Facility Social Worker, and other relevant professionals, may develop a transition plan based on an updated evaluation and input of the team, which can also serve as an interim Plan of Care to initiate services before the development of a full Plan of Care (WPA-2).

b) The Comprehensive Evaluation, on a Department approved evaluation tool, is completed by professional staff designated by the Department of Health and Senior Services to determine whether the applicant meets the clinical criteria of nursing facility level of care. The evaluation tool measures cognitive patterns; communication/hearing patterns; vision patterns; physical functioning (Self Performance of activities of daily living and instrumental activities of daily living); continence; disease diagnosis and disabilities; health conditions and preventive health measures; nutritional/hydration status; dental status (oral health); skin condition; service utilization of formal care and special treatments, or therapies; medications; environmental assessment; mood and behavior patterns; social functioning; informal supports; and an assessment summary.

Before developing the Plan of Care, the Care Manager reviews the initial Comprehensive Evaluation completed by the Office of Community Choice Options Staff or Professional Staff designated by the Department. The individual's Comprehensive Evaluation used to determine nursing facility level of care is also used in developing the Plan of Care.

Services are authorized by the Care Manager. All authorized services, which are identified in the participants Plan of Care, are based on an individual's assessed needs. Waiver services are arranged to complement and/or supplement (not replace) the services that are already available to participants through the Medicaid State Plan and other federal, state and local public programs as well as the supports that families and communities provide. The GO program is not

intended to off-set the cost of agencies paid for privately by other parties. Upon enrollment, a comprehensive Plan of Care is developed by the GO participant and his or her Care Manager. A need based care allocation tool was developed and is utilized as a consistent and objective means of assisting Care Managers (CM) in determining the hours of home and community based services a GO participant requires. The need based care allocation tool is used to assist Care Managers in determining a GO participant's care needs when developing the initial Plan of Care, the annual Plan of Care or when there has been a significant change in the participant's functional abilities or a significant change in caregiver status requiring a revision to the Plan of Care. GO participants are provided services based on the information recorded on the comprehensive evaluation and the need based care allocation tool while also considering the professional judgment of the Care Manager in determining hours of service. The need based care allocation tool is used in conjunction with the following documents, as applicable: Comprehensive Evaluation and the Re-evaluation of Nursing Facility Level of Care (WPA-1).

The state must provide for the consistent, uniform administration and operation of the Waiver across all geographic areas where the Waiver is in operation, which for the GO Waiver is statewide. For example, when the care management agencies (which are located in local/regional non-state agencies) perform waiver operational functions such as Plan of Care development, the state must ensure that consistent decisions are made about the authorization of waiver services wherever a GO participant may reside. While there may be local variations in how waiver operational functions are conducted, the results should be consistent jurisdiction-to-jurisdiction. Absent a waiver of 'Statewideness', it is expected that the GO waiver will be administered and operated in a consistent fashion in all parts of the state of NJ and, thereby, ensure that waiver services are provided on a comparable basis to the entire target group of GO waiver participants in compliance with 42 CFR §440.240(b) (comparability of services for groups).

The needs based care allocation tool assists the state in demonstrating that services available are equal in amount, duration, and scope for all GO participants based on their individual assessed needs. The GO Waiver is managed in a manner to promote the cost-effective delivery of home and community-based services, and the use of the need based care allocation tool assists in linking the delivery of waiver services to other state and local programs and their associated service delivery systems. If the Waiver Participant or his/her Authorized Representative does not agree to the hours determined by the need based care allocation tool and the professional judgment of the Care Manager, after discussing areas of concern directly with the care management site, he/she can request an administrative review by the DACS Quality Assurance Unit staff as warranted.

Upon receiving a referral for a newly enrolled GO participant, the Care Manager schedules a face-to-face meeting in the participant's residence to interview the participant and family/caregiver. During the face-to-face meeting, the Care Manager continues the evaluation process started by the assessor and observes the participant's interactions with those present; participant's ambulation/navigation ability; physical environment; cognitive status and appropriateness of participant's appearance. The Care Manager asks about changes in participant's support system(s), health conditions, hospitalizations/rehabilitations, ability to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), goals or preferences, new needs and preferences, and overall functioning and independence level since the Comprehensive Evaluation. The Care Manager also identifies and discusses any assessed risk factors and the need for a backup plan.

c) The GO Participant Handbook and a web-based Fact Sheet list all the services that are available in the Global Options for Long-Term Care program. In addition, a thorough Policy on GO Medicaid Waiver Service Definitions and Special Considerations, was distributed to all care management agencies, which describes each service, its standards, requirements and limitations. At the time of the initial inquiry into service availability and potential program enrollment, designated Staff provides Options Counseling to applicants about the services available through the GO Waiver and other home and community service programs. For those individuals in an institutional setting who are seeking relocation to the community, the Community Choice Counselor will discuss the Global Options for Long-Term Care program with eligible candidates.

d) The Plan of Care (WPA-2) has fields to ensure all dimensions of the service plan process are addressed. The fields indicate date, Problem Statement regarding the reason for the assessed needs, risk factors and personal goals, need codes, services warranted, desired outcomes, service delivery pattern (units and frequency), unit cost, payment source, provider type, provider name, monitoring method, monitoring frequency, back up plan (if applicable), and unmet needs (if applicable). The Plan of Care has a narrative section for special instructions/comments to incorporate participant preferences or concerns, expound on unmet needs, and describe back-up plans, explaining any situations considered to be at-risk concerns for the safety and/or well-being of the participant and listing the interventions to respond to such safety concerns including who is responsible with emergency contact information.

e) The Plan of Care Policy and Procedures, POC Form and Instructions, comprehensive evaluation tool, and need based care allocation tool are available to CMS upon request. The Plan of Care identifies the participant's services and the payment source for that service. If the service indicates Medicaid as the payment source, the Care Manager is

responsible to coordinate. Other possible payment sources are Medicare, other third party liability, community, informal support or other formal support. The Care Manager helps the participant secure services from these other payment sources.

f) The Care Manager oversees the implementation and the monitoring of the service plan. There are fields in the Plan of Care that indicate the monitoring method to identify how service provision will be verified: participant record/chart in an Assisted Living facility, client report, face to face visit with participant while service is occurring, observing participant and environment, receipts (review proof of payment, vouchers, or invoices of services delivered), documentation (review of assignment sheets, service delivery logs, medication or treatment administration records, telephone contact (telephone conversations with participant, caregiver, service provider, wellness nurse, or billing agent.) and the monitoring frequency (daily, weekly, biweekly, monthly, quarterly, annually, random, and other).

g) The Plan of Care is updated at least once a year or more often if participant's needs or circumstances change.

h) There is a participant signature line on the Plan of Care for the participant and/or his or her representative/legal representative to acknowledge his or her agreement with the Plan of Care process. In September 2007, another field was added to the Plan of Care (WPA-2) for the participant to sign to acknowledge he/she had choice in services and providers.

i) Assisted Living:

In NJ, when an individual moves into a licensed Assisted Living facility the Certified Assisted Living Administrator or Registered Nurse initiates a Plan of Care/General Service Plan within 72 hours of move-in. The Certified Assisted Living Administrator or Registered Nurse coordinates all services, including State plan services and services furnished through other State and Federal programs. The participant's strengths, capacities, needs, preferences, desired outcomes, health status and risk factors are considered. The responsible party (family member, Power of Attorney, etc.), participant, and Staff of the AL facility are included in all discussions about the care to be rendered to the individual, and agree to, and sign the Plan of Care/General Service Plan. The Plan of Care/General Service Plan includes an Evaluation of the needs of the individual, a Plan to meet those needs, the steps taken to Implement the Plans, identification of the person to implement the plan, and an Evaluation of the effectiveness of the steps taken. This Plan of Care/General Service Plan is reviewed at least monthly, monitoring notes are written as needed, but at least quarterly, and revised annually by the Certified Assisted Living Administrator or Registered Nurse.

The Care Manager reviews these plans and, if approved by the participant and/or his or her representative/legal representative, Care Manager and Care Management Site Supervisor as meeting the participant's needs, the assisted living facility's plan serves as the Plan of Care under this Waiver. The participant and/or his or her representative/legal representative, Care Manager, Care Management Site Supervisor, and facility designee sign a specially designed "Approval Form," which confirms agreement that the facility plan meets the individual's needs. If the Care Manager determines that the participant has additional needs not specified in the assisted living facility's plan(s), then a Plan of Care (WPA-2) is developed and given to the facility/program for implementation. The assisted living facility's/program's plan(s) is incorporated by reference into the WPA-2.

j) Adult Family Care:

When a client has been deemed eligible for the Adult Family Care Program, an initial interview is arranged between the participant, caregiver, responsible party (Power of Attorney, family member, etc.), and Care Manager. The participant's strengths, capacities, preferences, needs, desired outcomes, health status and risk factors are discussed, and all parties agree on what services are to be rendered and what services are available to the participant, and verify their agreement with the Plan of Care. This meeting is to be held within 30 days of move-in. The caregiver is made fully aware of the services to be rendered, and agrees to render those services to the participant. All rights and responsibilities are discussed, and the participant is afforded choice in services. The Plan of Care is based on an evaluation of the needs of the individual, a Plan to meet those needs, back up plans, the steps taken to Implement the Plans, coordination and oversight of all services by the Care Manager, including State Plan services and those furnished through other State and federal programs (Medicare), and an Evaluation of the effectiveness of the steps taken.

The Care Manager or Registered Nurse makes a home visit to the newly admitted client on the day of move-in and weekly for the first 4 weeks after move-in, and makes any necessary changes to the Plan of Care. The Care Manager and/or Registered Nurse continually assess compatibility of the client with the caregiver. The Plan of Care is reviewed again in 30 days and every 30 days thereafter. The Care Manager makes a face-to-face evaluation at least monthly, and the Plan of Care is revised or updated at that time or earlier if necessary. If the Care Manager is not a Registered Nurse, the Sponsor Agency's Registered Nurse visits the participant quarterly and makes any necessary revisions to the Plan of Care.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

- In the past, the Division's training unit offered Core Care Management training to all Care Managers. The Division also offered a one-day Continuing Education training on various topics to all Care Managers throughout the year. The trainings included risk evaluations of the home environment, health, behavior and personal safety. Care Managers have used this information from the trainings to assess potential risks of their participants. At this time, the Division's Quality Assurance Unit provides program training to new GO care management sites minimally on an annual basis. Specialized raining sessions and continuing education opportunities are developed and provided periodically, as DACS staff prioritizes topics in demand.
- Care Managers are trained to continually assess the participant with each contact (telephone, in-home visits). The Care Manager annually reevaluates the participant for level of care and to develop the Plan of Care updates. For those residing in an assisted living setting, GO participants receive regular monthly monitoring by the AL staff (i.e. Certified Assisted Living Administrator or Registered Nurse).
- Any assessed risk is identified in the Plan of Care in the need code field in the Plan of Care. The risk factors are those that address personal safety (supervision needed for personal safety; participant is self-neglecting, abusive of alcohol or other substance); health conditions (needs medical attention, visual impairments, obese, sedentary lifestyle, chronic illness, poor nutrition, sleep disturbance, poor health/hygiene, lack of oral/dental care, skin condition/bed sores, improper foot care, at risk of falls, at imminent risk of long-term institutional placement in nursing facility); behavioral conditions (risky or inappropriate behaviors or lifestyle habits); environmental conditions (home environment, living conditions are insecure or hazardous, neighborhood is unsafe; or medication risk (unable to appropriately manage medications, multiple medications and/or prescribing physicians) or any other factors. A corresponding field identifies the service needed to meet the risk and a separate field to State the desired outcome of the service. If the assessed risk cannot be mitigated by Plan of Care services then it will be listed as an unmet need on the Plan of Care. The possible repercussions of the lack of service will be discussed with the participant and/or his or her representative/legal representative and the participant/representative/legal representative acknowledges on the Plan of Care statements that affirm that 1) I have been advised of the potential risk factors outlined in this Plan of Care and 2) I understand and accept these potential risk factors.

A Plan of Care policy was originally distributed in September 2007 and then revised and updated in 2011. This Policy and Procedure fully addresses the standards established for all participant-centered service plans. The Plan of Care (WPA-2) has fields to ensure all dimensions of the service plan process are addressed. The fields indicate date, Problem Statement regarding the reason for the assessed needs, risk factors and personal goals, need codes, services warranted, desired outcomes, service delivery pattern (units and frequency), unit cost, payment source, provider type, provider name, monitoring method, monitoring frequency, back up plan (if applicable), and unmet needs (if applicable). The Plan of Care has a narrative section for special instructions/comments to incorporate participant preferences or concerns, expound on unmet needs, and describe back-up plans, explaining any situations considered to be at-risk concerns for the safety and/or well-being of the participant and listing the interventions to respond to such safety concerns including who is responsible with emergency contact information.

As stated, in the process of developing the Plan of Care, the Care Manager and GO Waiver participant/representative/legal representative identify any risk factors that would trigger the need for back-up plans, should services not be delivered. Back-up plans are needed if the provider identified as responsible for furnishing the services fails or is unable to deliver them and it would have a critical impact on the participant's immediate well being. Alternative arrangements for the delivery of services would therefore be imperative. This information is included in narrative form on the Plan of Care and addresses the interventions to respond to safety concerns including contact information for the person responsible. In addition to the back up plan strategies identified below, the availability of informal supports is discussed and identified in the Plan of Care, if viable. The Care Manager verifies that informal supports identified in the Plan of Care are valid. Listed below are some of the standard methods for addressing back-up plans:

- o Care Managers contact the participant monthly (in Assisted Living Facilities, it may be quarterly after the first three months of placement) and visit quarterly as part of their responsibility in monitoring the participant's needs. Unmet needs are identified at those times and detailed in the Plan of Care with reasons for unmet needs. Future service planning addresses how the unmet needs are to be met.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

GO participants are assisted by Care Managers in obtaining information about and selecting from among qualified providers of the Waiver services in the service plan. Care Managers have access to information databases that list approved providers.

For example, the NJ MMIS website maintains a provider database for all approved providers statewide in the form of a Provider Directory. This Directory options allows users, such as Care Managers or even participants, to search for potential providers by County, by Provider Type, by Provider Specialty, or by Provider name. The search results give the user information about the Provider, such as its address, its phone number, its email, its specialties, and whether or not its status is open to accept new consumers. In addition, the DACS Quality Assurance Unit also transmits a copy of any newly approved provider's Medicaid enrollment letter to the Care Management sites in the county wherein the provider is expected to deliver services for easy access to new information.

When the Plan of Care is being developed, the Care Managers have been instructed to share provider lists with the participant so the participant can choose a provider. The Plan of Care procedures require that the participant is informed of the availability through the program and that those in attendance for the Plan of Care development reach agreement on the services options that effectively meet the participant's needs, considering respect for the participant's preferences, optimization of available resources, and service cost effectiveness and feasibility.

Guided by participant choice and with Monthly Contacts and Quarterly Visits (face to face) with the participant at the required minimum, Care Managers routinely monitor authorized program service delivery with the participant and/or legal representative. During these required contacts, on an on-going basis, access to any and all willing, qualified and available providers, as well as provider performance, suitability and participant satisfaction are all discussed with the participant or his or her representative by the Care Manager. Care Managers are duty-bound and trained to respond to participant feedback about provider quality on an ongoing basis. When provider change is requested and/or needed, the Care Manager facilitates the necessary provider change.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The Quality Management Unit (QMU) of the New Jersey Department of Human Services' Division of Medical Assistance and Health Services (DMAHS, the Single State Agency), conducts annual comprehensive audits to exercise oversight of the Plans of Care on a routine and periodic basis. The Quality Management Unit uses its own comprehensive audit tool to assess two performance measures to assure that the Plan of Care services are based on assessed needs and is responsive to those needs. Each of the performance measures includes desired outcomes, indicators, evaluation criteria and data sources.

Samplings comprise retrospective reviews of randomly selected Waiver participant records as well as supporting documentation for no less than one complete Plan of Care cycle (12 months). The number of files reviewed is based on a statistically significant percentage of the records reviewed by the Division of Aging and Community Services during its Quality Assurance Surveys.

When documentation that the Plan of Care meets the Waiver assurances is lacking in more than 10% of the files audited, a Corrective Action Plan is required from the agency.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

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

- Medicaid agency
 Operating agency
 Case manager
 Other

Specify:

All Service Plans (Plans of Care) are kept with the Care Manager at the care management agency in the participant file in a locked cabinet or room.

In Assisted Living facilities and assisted living programs, a copy of the Plan of Care (WPA-2) or the Approval Form along with the AL facility's General Service Plan which meets the assessed needs of the participant, is kept on site at the AL facility/program's site as well as with the Care Manager at the care management agency in the participant's file.

For GO participants of the Adult Family Care option, a copy of the Plan of Care is kept with the Adult Family Care Caregiver and in the Care Manager's file at the Adult Family Care Sponsor Agency.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

a) Care Managers are responsible for monitoring the Plan of Care implementation and for monitoring the participant's health and welfare through regularly scheduled contacts and quarterly visits. Care Managers verify that services have been delivered by client report, on-site review, review of documented timesheets/service logs, or telephone contacts, and reconciling Service Cost Record Authorizations.

Care Managers observe whether activities, transportation, durable medical equipment and required supplies are available and adequate to meet the participant's needs.

Care Managers speak with participants/representatives/legal representative to question whether the individual has access to medical/dental/pharmacy services if in his or her own home or adequate assistance to receive these services if in a formal setting.

b) For GO participants in formal settings such as Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs, Care Managers are instructed to verify service delivery by completing a minimum of three of the following: 1) Observe the participant for cleanliness, appropriate clothing, grooming, and the general State of his or her room; 2) Speak with the participant about activities, services, and transportation to doctor visits; 3) Speak with the participant's contact person re: observations of care and/or satisfaction with services provided; 4) Speak with the Wellness Nurse to determine if the participant has observations/concerns about the individual's health or services; 5) Review the assignment sheets, triggered by the Plan of Care/General Service Plan; 6) Review the Service Delivery log; 7) review documentation of the resident's

response to services in chart or logs; and 8) Review the Medication Administration Record and/or Treatment Administration Record.

Care Managers also note whether the Staff is adequate to meet the needs identified in the Plan of Care as well as on an as-needed basis.

Care Managers check to see whether the professional AL Staff and Wellness Nurse have documented health care contacts, wellness checks, and other monitoring of the health and welfare of the participant to maintain or improve his or her well being.

Department of Health and Senior Services' Health Facilities Evaluation and Licensing (HFEL) Surveyors also audit the licensed facility's provision of services to see that the individual's health care needs are met, that a current plan of care exists, that pharmaceutical services are provided according to 8:36-11, that Social Work services are provided as necessary, that housekeeping, sanitation, safety, maintenance standards, and infection prevention and control services are met.

c) All GO participants and/or representatives/legal representatives are encouraged to report to the Care Manager any provider that is not providing services in accordance with the Plan of Care. The Care Manager promptly addresses any problems identified at that time.

d) In Adult Family Care settings, the AFC Caregivers and participants are visited monthly by the Sponsor Agency's Registered Nurse and/or Social Worker. Care plans are monitored at that time for documentation that services have been delivered as instructed and to assure that any special services that a participant needs are addressed. The Sponsor Agency Staff also have one-to-one time alone with the participant during the monthly visits and uses this time to check on participant satisfaction, adjustment, appropriateness of dress, and cleanliness of bedroom. Sponsor Agency Registered Nurses/Social Workers also make unannounced spot checks to assure that services are being provided according to the Plan of Care.

e) In addition, at the DACS Quality Assurance Unit's Survey Review, the County Liaisons/Quality Assurance Specialists review the participant files to verify that the Care Manager has monitored the Plan of Care services. Any problems identified from the Quality Assurance Unit's Survey are discussed with the care management agency in the formal exit interview and followed up promptly with a Findings Letter (Survey Report Summary) of noted deficiencies sent to the Care Management Agency's Director. Critical problems identified in the Quality Assurance Unit's survey are immediately followed up and remediated. A Remediation and Improvement Plan is required from the Care Management Agency for any identified problems and to be returned to DACS within a specified timeframe. The DMAHS' Quality Management Unit in Medicaid is copied on all letters sent to care management agencies with regard to the Division of Aging and Community Services' Quality Assurance Survey Visits, including the Finding Letters, and receives copies of Remediation and Improvement Plans, when required.

The DACS Office of the Assistant Commissioner' Quality Assurance Unit's Findings Letter and Report Summary gives the Care Management Agency 30 days to respond with a Remediation and Improvement Plan and evidence of corrections made, e.g., new policies, supplying missing documentation, etc. and steps to be taken to assure that the violation does not recur. If the initial Remediation and Improvement Plan is not satisfactory, the Care Management Agency receives a follow-up letter from the Office of the Assistant Commissioner outlining the additional areas that must be addressed in a revised Remediation and Improvement Plan. Should the revised Plan not be satisfactory, the following are examples of measures that would be taken by the DACS Quality Assurance Unit:

- o Increased monitoring of service provider, including a return visit.
- o Provision of technical assistance to address areas of concern.
- o Provision of training to improve Staff performance in areas of concern.
- o In extreme situations, the care management agency will not be permitted to accept new cases of GO participants recently enrolled; care management fees can be withheld or reclaimed; or a care management agency can be disenrolled as a Medicaid provider. In the latter case, the care management agency has the right to appeal this decision and is notified of such in the provider disenrollment letter. These measures are only taken in exceptional circumstances.

The DACS Quality Assurance Unit's survey review includes questions to assure that the participant/representative/legal representative has been offered choice of services and providers. Evidence that an individual has had a choice of providers is documented in the Monitoring Record in the Individual's file, participant interview, Care Manager Interview, Plan of Care, and Transition Plan for those entering the Waivers from a Nursing Facility.

The DACS Quality Assurance Unit requires back up plans to be identified in the Plan of Care if the absence of the service would be detrimental to the individual's well being. This standard is addressed in the Plan of Care policy.

As normal operational procedures, an agency's Care Management Supervisor is responsible for reviewing the Plan of Care to verify that Care Managers are in compliance with Plan of Care development requirements. At the time of the DACS Quality Assurance Units Survey, the DACS staff reviews the Plans of Care and monitoring notes of Care Managers to determine:

- Services are meeting the assessed needs of the participant.
- Services are being furnished in accordance with the service plan.
- Participant has choice in services and providers.
- Annual evaluation of participant is being completed.
- All non-Waiver services are identified.
- Providers are contacted periodically.

Any identified problems will be addressed in the Survey Report Summary and required Remediation and Improvement Plans.

f) The Care Manager contacts the participant on a regularly scheduled basis and has an in-person contact quarterly as part of the Care Manager's responsibility for monitoring. The monitoring frequency and method of monitoring used for each Plan of Care service is indicated on the WPA -2 (Plan of Care) form. Any problems identified by monitoring participants, service providers and others are noted in the monitoring notes along with documentation of follow-up activities to correct the problems.

Care Managers continually refer to the Plan of Care the service blueprint that documents the individual's service choices, needs and providers. Care Managers monitor authorized Waiver services as well as non-Waiver formal and informal services in their ongoing, required Monthly Contacts and face to face Quarterly Visits with the participant. More frequent contact between Care Manager and participant occurs routinely statewide.

Through ongoing care management monitoring (Monthly Contacts and face-to-face Quarterly Visits) of the participant's individual care and service needs, the Care Manager assesses and identifies any potential risks to the participant's well-being. Backup Plan development and risk assessment are critical components of on-going care management monitoring. As the participant's needs and high-risk circumstances change, Backup Plans and service considerations are modified. Monitoring the effectiveness of Backup Plans for any change/interruption/failure in needed service delivery is a Plan of Care programmatic requirement. Please refer to the response provided in Appendix D-1-e, Risk Agreement and Mitigation.

When care management agencies receive the Findings Letter and Report Summary from State Waiver surveyors, the process through which they respond to problems identified through the state review are as follows.

Care management agency administrative staff analyze the specific survey findings and develop a Remediation and Improvement Plan in response to specific problem areas within their Waiver service delivery. Noted responses include:

- Staff training covering targeted Waiver policies and procedures is provided to all Care Managers to address the problems cited.
- Missing programmatic documentation (evidence of corrective action) is supplied to the State survey team.
- Any weaknesses in communication channels are recognized with a remediation plan.
- Critical staff may be reassigned to strengthen service delivery.
- Technology upgrades and agency operations expenditures may be necessary.
- Internal agency policies are developed to address cited problem areas.

b. Monitoring Safeguards. *Select one:*

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

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

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

- The participant has the option to choose a different provider at any time.
- At the time of the DACS Quality Assurance Unit's Survey, DACS staff reviews participant files to determine provider utilization and seeks evidence that the participant has had choice of services and providers. Any conflicts identified are assessed by the DACS staff to determine if actions must be taken to address provider conflicts of interest.
- At the time of the in-home visits with the participants, DACS staff will question if the participant is receiving services as indicated in the Plan of Care. Any conflicts identified are addressed with the Care Manager as well

as actions to be taken if necessary.

- Participant Satisfaction Surveys mailed to participants ask if he/she is receiving services as stated in the Plan of Care. Any conflicts identified are addressed.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

i. Sub-Assurances:

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Number and percent of GO participants who have current Plans of Care in their records as maintained by their care management agency.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Care Management Supervisors	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from each Care Manager, opened during past

		3years, calculating sample size with Conf Intvl of 5; Confidence Level of 95%; Pop Size:# of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of Plans of Care are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

Performance Measure:

Number and percent of Plans of Care that address formal services and informal supports as assessed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

collection/generation <i>(check each that applies):</i>	<i>(check each that applies):</i>	
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Care Management Supervisors	<input checked="" type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from each Care Manager, opened during past 3 years, calculating sample size with Conf Intvl of 5; Confidence Level of 95%; Pop Size:# of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of Plans of Care are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

Performance Measure:
Number and percent of Plans of Care that address risk factors as assessed and back up plans as warranted.

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

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Care Management Supervisors	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from each Care Manager, opened during past 3 years, calculating sample size with Conf Intvl of 5; Confidence Level of 95%; Pop Size:# of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of Plans

		of Care are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

Performance Measure:

Number and percent of Plans of Care that document any unmet needs as assessed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Care Management	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from

Supervisors		each Care Manager, opened during past 3 years, calculating sample size with Conf Intvl of 5; Confidence Level of 95%; Pop Size: # of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of Plans of Care are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

Performance Measure:

Number and percent of Plans of Care that address the participant's personal goals.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

--	--

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Care Management Supervisors	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from each Care Manager, opened during past 3 years, calculating sample size with Conf Intvl of 5; Confidence Level of 95%; Pop Size:# of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of Plans of Care are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Number and percent of participant records with evidence that each participant's Plan of Care is based on the individual's completed comprehensive evaluation and needs based care allocation tools.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Care Management	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from

Supervisors		each Care Manager, opened during past 3 years, calculating sample size with Conf Intvl of 5; Confidence Level of 95%; Pop Size: # of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of Plans of Care are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

Performance Measure:

Number and percent of Plans of Care that are completed within 30 days of the Care Manager receiving the case.

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Care Management Supervisors	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from each Care Manager, opened during past 3 years, calculating sample size with Conf Intvl of 5; Confidence Level of 95%; Pop Size: # of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of Plans of Care are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

Performance Measure:
Number and percent of Plans of Care that are signed by all appropriate parties, including the participant, the Care Manager, and the Care Management Supervisor after reviewed as meeting the participant's assessed needs.

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

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Care Management Supervisors	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from each Care Manager, opened during past 3years, calculating sample size with Conf Intvl of 5; Confidence Level of 95%; Pop Size:# of Enrolled participants; Response Distribution of 50%

<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of Plans of Care are audited by each CM Supervisor at least annually.
<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Number and percent of Plans of Care that are reviewed and revised, as necessary, to address changing needs, at least annually.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Care Management Supervisors	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from each Care Manager, opened during past 3 years, calculating sample size with Conf Intvl of 5; Confidence Level of 95%; Pop Size:# of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of Plans of Care are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Number and percent of participant records with evidence that Care Managers monitor and verify the delivery of waiver services, as authorized in the Plan of Care by consulting with and observing the participant and documenting such contacts in the participant’s Monitoring Record.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

<p>Care Management Supervisors</p>		<p>Records from each Care Manager, opened during past 3 years, calculating sample size with Conf Intvl of 5; Confidence Level of 95%; Pop Size: # of Enrolled participants; Response Distribution of 50%</p>
	<p><input type="checkbox"/> Continuously and Ongoing</p>	<p><input checked="" type="checkbox"/> Other Specify: A random sample of participant records are audited by each CM Supervisor at least annually.</p>
	<p><input checked="" type="checkbox"/> Other Specify: Every two years</p>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<p><input type="checkbox"/> State Medicaid Agency</p>	<p><input type="checkbox"/> Weekly</p>
<p><input checked="" type="checkbox"/> Operating Agency</p>	<p><input type="checkbox"/> Monthly</p>
<p><input type="checkbox"/> Sub-State Entity</p>	<p><input type="checkbox"/> Quarterly</p>
<p><input type="checkbox"/> Other Specify:</p>	<p><input type="checkbox"/> Annually</p>
	<p><input type="checkbox"/> Continuously and Ongoing</p>
	<p><input checked="" type="checkbox"/> Other Specify: Every two years</p>

Performance Measure:

Number and percent of participant records with evidence that Care Managers monitor and verify the delivery of waiver services, as authorized in the Plan of Care by consulting service providers periodically and documenting it in the

participant's Monitoring Record.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Care Management Supervisors	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from each Care Manager, opened during past 3 years, calculating sample size with Conf Intvl of 5; Confidence Level of 95%; Pop Size:# of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of participant records are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

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Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

Performance Measure:
Number and percent of participant records with evidence that Care Managers monitor and verify the delivery of waiver services as authorized in the Plan of Care by reconciling Service Cost Records quarterly.

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

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Care Management Supervisors	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from each Care Manager, opened during past 3 years, calculating sample size with Conf Intvl of 5; Confidence Level of 95%;

		Pop Size:# of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of participant records are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Number and percent of participant records that include a signed Choice of Care form that specifies choice was offered between institutional care and waiver services.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Care Management Supervisors	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from each Care Manager, opened during past 3 years, calculating sample size with Conf Intvl of 5; Confidence Level of 95%; Pop Size:# of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of participant records are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

Performance Measure:

Number and percent of participant records with evidence that participants are afforded choice between waiver services

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Care Management Supervisors	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from each Care Manager, opened during past 3 years, calculating sample size with Conf Intvl of 5; Confidence

		Level of 95%; Pop Size:# of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of participant records are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

Performance Measure:

Number and percent of participant records with evidence that participants are afforded choice among all willing and qualified service providers.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Care Management Supervisors	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from each Care Manager, opened during past 3 years, calculating sample size with Conf Intvl of 5; Confidence Level of 95%; Pop Size:# of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of participant records are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

Performance Measure:

Number and percent of participant records with a participant-signed copy of the cover page of the GO Participant Handbook as evidence that the participant was made aware of the opportunities for choice and service delivery within the program.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Care Management Supervisors	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from each Care Manager, opened during past 3 years, calculating sample size with Conf Intvl of 5; Confidence Level of 95%; Pop Size: # of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of

		participant records are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

Performance Measure:

Number and percent of DACS solicited Conflict of Interest/Self-Referral Surveys completed biennially by care management agencies who not only have the responsibility for Plan of Care development but who also may provide other direct Waiver services to GO participants.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Conflict of Interest/Self-Referral Survey

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

<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

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

Care Managers prepare an initial Service Plan, known as a Plan of Care (POC), based on the original assessment completed by professional staff from the Office of Community Choice Options (OCCO), which has components to evaluate the health and safety risk factors of the participant. Care Managers also complete their own evaluation during the initial visit with the participant. POC development includes consideration of participant and caregiver preferences and goals, the attending physician's recommendations, consultation with any informal supporters, the participant's medical and social needs, and safety and risk factors. The POC is reviewed and signed by the participant and/or his representative, the Care Manager, and the Care Management Supervisor.

Participant File Review

Starting in May 2005, a new Participant File Review Tool was created, and subsequently improved, to be used by DACS County Liaisons to evaluate participant files maintained by Care Management sites. A sample of participant files is reviewed for evidence that participants' assessed needs are addressed in the Plans of Care (POC). In addition, files are audited to ensure that any unmet needs are identified, risk factors are assessed and

documented in the Plan of Care, and back-up plans are established as warranted. DACS County Liaisons review participant files for evidence that current comprehensive Plans of Care include the specified type, amount, duration, scope and frequency of services needed. The files are also reviewed for evidence that the Care Manager is verifying that services are actually being delivered in accordance with the POC. During the DACS Quality Assurance reviews of the Care Management agencies, participant files are examined to check whether the participant signed the Choice of Care form (CP-6) and if there was a copy maintained in the file. The monitoring tool also questions whether the participant had a choice in the programs, services, and providers being utilized and also questions if the personal goals of the participant are reflected in the POC. The GQ continues to monitor all of the current care management agencies on a 24 month cycle or more frequently as needed. All files are reviewed for the inclusion of a current and comprehensive POC, the timeliness of the development of the initial POC, the timeliness of consecutive Plans of Care, and that the POC includes all formal and informal assessed needs, as well as unmet needs. Ensuring that Plans of Care are developed by Care Managers in accordance with policies and procedures is one of the responsibilities of the Care Coordinators/Care Management Supervisors, who review and sign-off on each POC.

Participant Satisfaction Survey

Moreover, individual participants, currently enrolled or previously enrolled, as well as caregivers of participants are surveyed periodically regarding satisfaction with the services they receive and program enrollment overall. Participant feedback is solicited through mass-mailed surveys. DACS initiated the development of a simple, user-friendly, one-page mailed Participant Questionnaire which could be returned in a self-addressed stamped envelope and then data entered into a database so aggregate reports could be generated.

Provider Training

DACS Quality Assurance staff has provided training annually since 2006 to Care Managers which have included advisement regarding the necessity to revise a Plan of Care when participant's condition warrant. In addition, in January 2009, the GQ staff designed a tool, the Needs-Based Care Allocation Tool (NBCAT), to assist Care Managers in comprehensively determining a participants care needs. The NBCAT is an objective tool, with a weighted scale index, scored based on a point system. This tool is to be completed when developing the initial Plan of care, the annual Plan of Care or when there has been a significant change in the participant's functional abilities or a significant change in caregiver status requiring revision to the Plan of Care. The NBCAT is to be used in conjunction with the NJ Choice level of care evaluation/comprehensive assessment, Interim Plan of Care and Re-evaluation of Nursing Facility Level of Care. Total Need-Based Score of the NBCAT translates to the number of hours allocated for ADL/IADLS formal care assistance thereby helping the Care Managers as a guide for service planning. Global Options participants who opt for home and community-based services, as opposed to Assisted Living or Adult Family Care settings, have a spending cap for Waiver services of \$2,841 a month, including Care Management. This typically correlates into approximately 40 hours of care services.

b. Methods for Remediation/Fixing Individual Problems

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

Remediation and Improvement Plans

When the Quality Assurance Unit identifies problems during monitoring reviews, such concerns are discussed with the Care Management Supervisors on-site during the Exit Interview. A Summary Report follow-up letter outlines all deficiencies and concerns and requests that a Remediation and Improvement Plan (RIP), previously known as a Corrective Action Plan, be submitted to DACS within 30 days. Inadequate Remediation and Improvement Plans result in requests for additional information or instruction as to actions to be taken and, if needed, GQ conducts a subsequent survey site visit. All of the Remediation and Improvement Plans are accepted only when proof of the following was included: A) A copy of the cited document with applicable amendments attached. For document deficiencies that cannot be corrected with an amendment, a policy statement addressing how the agency will implement corrective actions in the future is requested; B) The actions to be taken (such as staff education, forms or policies to be revised) to ensure that deficiencies do not recur; C) The person(s) responsible for implementation; and D) A description of how each deficient area will be addressed in the Agency's Quality Improvement program.

- ii. **Remediation Data Aggregation**

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

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

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

c. Timelines

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

No

Yes

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

Appendix E: Participant Direction of Services

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

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

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

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

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

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

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how

participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Participants may elect to engage in participant-directed services, acting as the employer of their care providers. The participants must be willing and able to direct their care and perform essential employer functions, such as interviewing, checking references, hiring, supervising, and firing. The ability to direct one's care shall be confirmed prior to the approval to hire one's employee. An individual's ability to hire may be reevaluated at any time, as determined by the Care Manager, in response to objective evidence indicating changes in capability. An individual may opt to use an authorized representative approved by the Department to act on his or her behalf, except in attendant care. Attendant care pertains to health related tasks. This could include nursing tasks such as insulin injections to tracheostomy care. New Jersey's protocol for attendant care as well as other tasks performed by the Participant-Employed Provider was approved by the New Jersey Board of Nursing. It made sense that since attendant care permits the performance of health related tasks that could have serious consequences if not completed correctly, the risk of directing the Participant-Employed Provider to perform these tasks should be a risk that only the participant takes.

The Participant-Employed Provider must meet the following minimum requirements: be at least 18 years old, successfully complete a State and Federal criminal background investigation, be a United States citizen or a legal alien authorized to work in the U.S., be able to communicate with the participant, be physically capable of performing the service, respect the rights of the participant, including the practice of confidentiality, and be able to read and write at a level sufficient to follow written instructions and maintain records required in the performance of their duties. The Participant-Employed Provider may provide Chore, Home-Based Supportive Care (Assistance with Activities of Daily Living and Instrumental Activities of Daily Living), Transportation, and Attendant Care services and must have demonstrated the experience, training, education or skills necessary to meet the participant's needs, consistent with program standards for the task. Demonstration is accomplished through: documentation of formal training or education; previous experience; written documentation from previous employers; ability to clearly and effectively explain, verbally or in writing, specifically how the task is to be accomplished; and through actual observation of task performance. The Care Manager verifies that the Participant-Employed Provider meets the qualifications identified for the particular service.

A contracted Financial Management Services acts as agent for the participant/employer in performing fiscal responsibilities associated with processing payroll and withholding obligations. This is an administrative function and not a separate Waiver service.

The Care Manager notifies the Financial Management Services to send the employee/employer packets to the participant. The employer packets are pre-populated with the participant information and have tabs to indicate where the participant needs to sign. The participant completes the forms and returns them to the Financial Management Services with proof of Workman's Compensation coverage. Both the participant and Care Manager are given information sheets about Worker's Compensation. If the participant needs to apply for Worker's Compensation, a completed sample form is given to the participant for guidance in completing the form. The participant pays for the Worker's Compensation if it is not already included in his or her homeowner's policy. The price ranges from \$17 a year for part-time employees to \$75 a year for full-time. The Financial Management Services reviews the Workman's Compensation verification and sends the forms to the appropriate federal and State agencies. The Financial Management Services sends the employee packet to the participant. (The packet can also be downloaded from the Financial Management Services' web site.) The Participant completes the forms and sends them to the Financial Management Services. The Financial Management Services reviews the Participant tax form for completion and processes the forms. The Financial Management Services notifies designated Staff in the Division of Aging and Community Services, who updates the Participant-Employed Provider database and notifies the Care Coordinator/Care Management Site Supervisor of the approved start date for the Participant-Employed Provider to begin work. Once the packets are returned to the Financial Management Services and the fingerprints are completed a start date is given. The whole process takes from two to three weeks.

The Participant supervises and directs the employee in the provision of services as specified in his or her Plan of Care. The Plan of Care is developed by the participant, Care Manager, and other pertinent individuals requested by the participant, and is based on careful evaluation of needs, personal preferences, current supports, abilities, and risk factors. The Plan of Care drives service linkage and monitoring.

The Care Manager formally monitors implementation of the Plan of Care, which identifies minimum monitoring frequency, methodology to verify serviced provision and service outcomes. The Care Manager is also available to the participant to provide support in Participant-Employed Provider service delivery as needed to ensure the health, safety, welfare and rights of the individuals receiving services.

A service agreement is mandatory for each Participant-Employed Provider, which delineates the specific care, as identified in the Plan of Care, to be provided in terms of type, amount, duration, and frequency. Care Managers complete an Individual Service Agreement (ISA) on the DACS Database website (formerly called the HCBS - Home and Community-Based Services website) to document the above. The Financial Management Services matches the timesheet signed by the participant/employer, against the Individual Service Agreement authorization to ensure that the approved hours of Participant-directed services are the same.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Participant: Employer Authority. As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

Participant: Budget Authority. As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

Both Authorities. The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

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

- Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Global Options affords the provision of home and community-based waiver services to be delivered in these specified living arrangements: the individual's own private home/apartment or that of a family member, a licensed, Medicaid-approved assisted living facility [either Assisted Living Residence (ALR) or Comprehensive Personal Care Home (CPCH)], a Medicaid-approved Adult Family Care (AFC) home, or a licensed Class B Boarding Home.

Of those living arrangements, the Participant Direction opportunity of Employer Authority is only available to GO participants 1) who reside in their own private home or that of a family member or 2) who reside in a Class B Boarding Home. The participant direction opportunity of Employer Authority is not available to GO participants who choose to reside in an ALR, CPCH, or AFC. Additionally, if the individual resides in their own apartment in a subsidized housing building and simultaneously chooses to participate in the building's available Assisted Living Program (ALP) he or she could not also exercise the Employer Authority option.

For more information on the community-based living arrangement characteristics of ALR/CPCH, ALP in Subsidized Housing, and AFC, please see the applicable Service Definition section in Appendix C of this application.

More information on the home and community-based characteristics of the Class B Boarding Home living arrangement is provided here.

Class B Boarding Homes: If a home serves more than one person unrelated to the proprietor, it must get a Boarding Home License. The Class B Boarding Home License is valid for a boarding house that offers no financial services and no personal services other than meals, other food services, and laundry. A specific

Boarding House License, e.g., Class B Boarding Home, is issued according to the services it provides and not by the number of people served. The NJ Department of Community Affairs licenses the Class B Boarding Homes; they are designed for individuals who can live independently or independently with services. The number of Units depends upon the size of the facility. Per NJAC 5:27-9.3 (a) each resident shall be served at least three well-balanced & appetizing meals per day on a regular schedule & at reasonable intervals. Per NJAC 5:27-9.3 (b) food & beverages shall be available to residents in reasonable quantities for between-meal and evening snacks. Per NJAC 5:27-6.1 (b) every resident of every boarding house operated under a Class B license shall be provided with a key to the main entrance door and, if applicable, to his or her rooming unit door, free of charge. Replacement keys, when required, shall be provided at cost. Per NJAC 5:27-8.1 (b) 2 a resident may choose to either rent a private rooming unit or share the rooming unit with one or more persons. A lease or other occupancy agreement signed by both the licensee and the resident clearly states the services to be provided by the licensee & the charge to the resident for such services. Residents in Class B facilities typically rent private rooms. Per NJAC 5:27-3.6 a licensee shall take such affirmative action as may be necessary to assist each resident in living with as much independence & autonomy & with as high a degree of interaction with the community as may be reasonably possible. Per statute NJSA 55:13B-19 j every resident of a boarding facility shall have the right to make contacts with the community & to achieve the highest level of independence, autonomy, & interaction with the community of which he is capable.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Waiver is designed to support only individuals who want to direct their services.

The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

All participants are offered the opportunity to exercise choice and control in identifying, accessing, and managing Waiver services and other supports in accordance with their needs and personal preferences. If the participant indicates he or she is interested in directing at least one of his or her services, including the use of a Participant-Employed Provider, the Care Manager will assess the participant's ability to self-direct and to fulfill the obligations of an employer. If the participant indicates a desire to hire his or her own employee, but does not wish the full responsibility, he can select a legal representative to act in this capacity for him or her. The Care Manager will assess the legal representative to determine ability to act on behalf of the participant. The Care Manager, with the participant, will determine what services (as determined by the assessed need) the Participant-Employed Provider will be performing for the participant. The Care Manager will verify if the participant/legal representative can direct his or her services by using the following criteria:

- The participant will explain or demonstrate to the Care Manager how the participant will direct the Participant-Employed Provider step by step in performing the identified services. The participant will have to prove that he or she knows how the identified service is to be performed and knows how to direct someone in completing the task.
- Care Manager will conduct a face to face interview with the participant about self direction
- Care Manager and participant will review the Participant Guidebook on "Employing Your Own Home Care Service Providers" with the Participant to evaluate the participant's understanding of his or her obligations in self-directing
- Care Manager and participant will review the Participant Workbook on using "Participant Employed Providers" to evaluate the participant's understanding of his or her obligations in self-directing.
- Care Manager will review the Level of Care/Comprehensive Evaluation completed on the participant to determine, participant's strengths and weaknesses in self-directing.
- Care Manager will review file documentation on the participant to determine any strengths and weaknesses of

the participant in self-directing.

- Care Manager will solicit answers from the participant using the tool "Participant's Capacity for Self-Direction, Capacity for Self-Direction" guide (15 questions designed to evoke responses from the participant that will demonstrate an understanding of his or her abilities)

If the Participant chooses not to self-direct or does not demonstrate the ability to supervise service provision and/or would be at undue risk by participating in the program in this capacity and there is no available legal representative to act in his or her stead or it is not appropriate to use one, the determination is discussed with the participant and plans are made for assessed needs to be provided by a different provider type. There must be clear indicators in both the Level of Care/Comprehensive Evaluation and responses to questions in the Participant's Capacity for Self-Direction, to validate the inability to engage in this level of participant-directed services. A diagnosis in and of itself would not preclude a participant from participating in self-direction.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Potential applicants will receive Options Counseling before enrolling in a Waiver program when level of care evaluations are performed by Community Choice Counselors and professional staff designated by the Department. The applicant will receive general information on Participant-Directed Services opportunities. Any applicant interested in receiving home and community-based services as an alternative to nursing facility placement will be advised on the various programs and services available through an array of options, not only the Global Options program. If an applicant's care needs can be met through the provision of State Plan Services, and waiver services are not warranted, Medicaid Waiver enrollment is not appropriate to pursue. If an applicant wishes to self-direct in the State Plan Service of Personal Care Assistant, he or she can pursue the Personal Preference Program as part of that State Plan Service. The Personal Preference Program gives participants the opportunity to exercise Budget Authority and/or Employer Authority through self-direction.

If GO Waiver services are warranted and otherwise eligible applicants choose to enroll on GO, participants receive a Participant Handbook which describes the Waiver program, services available, the Plan of Care, Care Management information, and Participant-Directed Care. After receiving this information, if the Participant indicates the desire to act as the employer of his or her provider/worker, the Care Manager will then discuss with the participant the details of self-directing options. If the participant is interested in using a Participant-Employed Provider, the Care Manager will explain the responsibilities of being a provider, and the participants are furnished with information about the benefits and liabilities of hiring your own employee. Depending on the interest of the participant these discussions may occur prior to enrollment or anytime after enrollment. The Care Manager will give the participant the following information associated with participant direction:

- Copy of the "Client Workbook," which the participant uses to establish the list of tasks that must be completed to adequately meet his or her assessed needs; qualifications and skills for the providers of his or her services; time frames, materials, supplies needed; and requirements/expectations for service and outcomes. The Workbook is also used to plan for emergency back-up service when a provider is unavailable, describe orientation information he or she would provide to an employee including any particular medical needs or concerns, household rules, and emergency information the employee needs to know.
- Copy of the "Employer's Guidebook" to assist him or her in understanding and developing potential Participant-Employed Providers and his or her responsibilities as an employer. This information is used in the care planning process to assist the participant or team to identify which of the needs the Participant wishes the Participant-Employed Providers to address. It is also used to establish the parameters of service. The Employer's Guidebook assists the participant in understanding the benefits and liabilities of hiring your own employee, which the Care Manager discusses with the participant. The Guidebook instructs that the participant will be responsible for finding, selecting, qualifying, hiring, training, supervising, evaluating and terminating his or her own employees. It provides information on interacting with the Financial Management Services and also how to develop a back-up plan.
- Employer and employee checklist (an itemization of the documentation that has to be completed by the participant and the Participant-Employed Provider.
- Information for the participant on how to secure Worker's Compensation through the participant's homeowners

insurance or separate worker's compensation policy.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

The State does not provide for the direction of waiver services by a representative.

The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

- Waiver services may be directed by a legal representative of the participant.**
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The Spouse is the only legal representative that may direct Waiver services without additional proof of authorization. All others must have legal documentation, such as a Power of Attorney or Guardianship that authorize the person to act on behalf of the participant.

The spouse or legal representative must be willing and competent to assume the responsibilities, be available to direct care during the times of service identified in the Plan of Care, and would provide the care him or herself if physical limitations or bona fide conflicts did not prevent him or her from doing so. A legal representative must be a person who has sufficient knowledge of the participant's circumstances to provide necessary information to the worker, at least 18 years old, authorized in writing, by the competent participant or duly recognized legal authority, to act on the participant's behalf, and approved by the Department.

A legal representative may not be: the individual's Participant-Employed Provider, member of a county group governing in any way the operations of a Care Management site, a worker who determined participant eligibility for the program in which the participant is enrolled, special investigative Staff, or monetarily compensated for his or her services in this capacity. Use of a legal representative may occur when the following steps have been taken: completion of a Designation of Legal Representative form, submission to the Division of Aging and Community Services with proof of Legal Representative Status; and confirmation of receipt is provided to the Care Coordinator/Care Management Supervisor. (No legal representative may be used in Attendant Care.)

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. **Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Chore Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Home-Based Supportive Care	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Attendant Care	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Transportation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

Yes. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

- Governmental entities
- Private entities

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.
Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

FMS are covered as the waiver service specified in Appendix C1/C3

The waiver service entitled:

FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The Financial Management Services utilized is a private for-profit entity whose Financial Management Services were procured through the Department of Treasury, Division of Purchase and Property, according to the requirements of N.J.A.C. 17:12. A Request For Proposal was issued and a bidding process ensued that led to a contract between the Financial Management Services and the State Division of Purchase and Property to provide specific Financial Management Services for Waiver participants.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The Financial Management Services provider receives a monthly transaction fee, decided during contract negotiations, for bi-weekly payroll processing.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies):*

Supports furnished when the participant is the employer of direct support workers:

- Assists participant in verifying support worker citizenship status**
- Collects and processes timesheets of support workers**
- Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- Other**

Specify:

The Financial Management Services also is under contract to: Develop a Participant-Employed Provider manual; b) Develop a Provider Instructional Manual; c) Participate in/provide training sessions for Care Managers and Division of Aging and Community Services Staff; d) provide technical assistance to providers regarding billing/payment issues; e) and establish a quality assurance program to monitor the performance of internal controls and to ensure compliance and detect fraud. The Financial Management Services provides Customer Service to Participant-Employed Providers and their employees re: timesheet/paperwork completion and submission; support to Care Managers, assistance to Participant-Employed Providers, to resolve claim discrepancies, verification that claims are paid in accordance with applicable Individual Service Agreements, and provides year end tax information to employers & Participant-Employed Providers. In addition, the Financial Management Services notifies all providers when claims are pending, reviews the pending claim file for follow-up on problem resolutions, and issues payments to providers if approved through the Division of Aging and Community Services (DACs) Database.

Supports furnished when the participant exercises budget authority:

- Maintains a separate account for each participant's participant-directed budget**
- Tracks and reports participant funds, disbursements and the balance of participant funds**
- Processes and pays invoices for goods and services approved in the service plan**
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- Other services and supports**

Specify:

Additional functions/activities:

- Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- Other**

Specify:

- iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The Division of Aging and Community Services maintains a DACs Database website, which was designed so the Care Manager can set up approved Waiver services only with non-traditional providers that have been

approved by the Division for individuals enrolled in the Waiver. The Care Manager enters an Individual Service Agreement (ISA) onto the website to authorize monthly payment amounts to each non-traditional provider for every approved Medicaid Waiver service to be delivered to a specific participant. The authorization includes the individual's name, Medicaid number, service to be delivered, number of units, frequency, amount and cost. The DACS Database System feeds this authorization information to the Financial Management Services. If a provider bills for a service that is not authorized or for more than the monthly-authorized amount, the fiscal agent will not pay the provider.

The Financial Management Services contract mandates performance measures for the accuracy and timeliness of the following tasks: submission of bills and invoices, payment to providers, payment of wages to Participant-Employed Providers, length of processing times, record keeping, updating of manuals and instructions, training in response to requests and changes in regulations, resolution of claims discrepancies, and resolution of conflicts between participant-employers and Participant-Employed Providers.

The Financial Management Services is under contract to develop monthly reports detailing the outcomes of the performance measures for submission to the contract manager on a monthly basis. The report must include narrative explanation of the analysis, findings, trends, corrective actions taken and outcome measures. The DACS Supervisor of the Data Management Unit has received all the paid claim data as of the beginning of the contract and runs and reviews reports of performance measures based on this information on a regular basis.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The Care Manager explains the Participant-Employed Provider process to participant, assesses participant for self-direction capabilities, and provides the participant with the Employer Guidebook, Client Workbook, Certification of Qualifications (a check-off list that participant uses to confirm Participant-Employed Provider's ability to perform desired tasks), Criminal Background Packet for qualified Participant-Employed Provider candidate, and Employer/Employee Instruction Packages.

The Care Manager reviews the Participant-Employed Provider qualifications with the participant (separate qualifications, limitations and standards for Attendant Care, Chore Service, Home-Based Supportive Care, and Transportation), explains the employee and employer packages of information, assists the participant to secure needed workman's compensation insurance, develops the Plan of Care with participant and others to include the participant-directed services, monitors Participant-Employed Provider services during a monthly phone call and/or quarterly visit, and notifies the Division of Aging and Community Services when the Participant-Employed Provider is no longer active.

- Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (*check each that applies*):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Respite	<input type="checkbox"/>
Chore Services	<input type="checkbox"/>
Social Adult Day Care	

	<input type="checkbox"/>
Adult Family Care	<input type="checkbox"/>
Care Management	<input type="checkbox"/>
Personal Emergency Response System (PERS)	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>
Transitional Care Management	<input type="checkbox"/>
Environmental Accessibility Adaptations (EAA)	<input type="checkbox"/>
Home-Delivered Meals	<input type="checkbox"/>
Assisted Living Program (ALP) in Subsidized Housing	<input type="checkbox"/>
Home-Based Supportive Care	<input type="checkbox"/>
Attendant Care	<input type="checkbox"/>
Assisted Living (ALR or CPCH)	<input type="checkbox"/>
Caregiver Participant Training	<input type="checkbox"/>
Transportation	<input type="checkbox"/>
Community Transition Services	<input type="checkbox"/>

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

No. Arrangements have not been made for independent advocacy.

Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Participants are instructed that a Participant-Employed Provider is a provider type and not a service. They are informed that it is their choice whether they want to receive specific services from an employee they direct or from an alternate service delivery method. The reason for the request to change to a provider-managed service is ascertained, evaluated and discussed with the participant. If it is apparent that the participant no longer wishes to direct his or her own services, documentation of the fact and reasons for it are entered into the participant’s record. The Care Manager immediately refers the service request to an approved provider identifying the units, frequency, and duration of the service that the participant requires to meet the assessed needs. Once an available provider is located, the Plan of Care is updated to reflect the change, and a start date is assigned. Until the provider-directed services can begin, the participant is encouraged to retain the current Participant-Employed Provider or to identify informal supports to provide the service. If the participant declines to keep the Participant-Employed Provider during this transition, or the Participant-Employed Provider was not adequate to the task, or if there are no informal supports, risks are explained and a back-up emergency plan is devised and implemented until such time as the new provider starts service provision.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Participant direction is encouraged and supported for the participant that has expressed a desire for this mode of service delivery. However, involuntary termination of participant direction may be necessary when:

- The participant is unwilling or unable (based on experience and/or additional evaluation) to carry out the functions of an employer such as supervising, evaluating or directing the Participant-Employed Provider in performing the service or parameters established in the planning process are violated.. (The participant will have the option of using an approved authorized representative before being terminated from participant direction.)
- The participant no longer has the ability to understand how to perform the service the Participant-Employed Provider is providing. (The participant will have the option of using an approved authorized representative before being terminated from participant direction.)
- The participant’s condition changes where he or she no longer needs assistance with Activities of Daily Living/Instrumental Activities of Daily Living services but requires health-related services. (The participant will be offered the option for an evaluation to use Attendant Care before being terminated from participant direction.)

The participant will not be terminated from the Waiver, but will be given provider-managed services, in accordance with the participant’s wishes and available providers. As in section E-1-l above, the Care Manager refers the service request to an approved provider identifying the units, frequency, and duration of the service that the participant requires to meet the assessed needs. Once an available provider is located, the Plan of Care is updated to reflect the change, and a start date is assigned.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants

Year 1	285	
Year 2	297	
Year 3	309	
Year 4	321	
Year 5	332	

Appendix E: Participant Direction of Services

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

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

i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

- Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

- Recruit staff**
- Refer staff to agency for hiring (co-employer)**
- Select staff from worker registry**
- Hire staff common law employer**
- Verify staff qualifications**
- Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

- Determine staff wages and benefits subject to State limits
- Schedule staff
- Orient and instruct staff in duties
- Supervise staff
- Evaluate staff performance
- Verify time worked by staff and approve time sheets
- Discharge staff (common law employer)
- Discharge staff from providing services (co-employer)
- Other

Specify:

Appendix E: Participant Direction of Services

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

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

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget
- Determine the amount paid for services within the State's established limits
- Substitute service providers
- Schedule the provision of services
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- Identify service providers and refer for provider enrollment
- Authorize payment for waiver goods and services
- Review and approve provider invoices for services rendered
- Other

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Individuals who are (a) denied participation in Global Options; (b) denied the service(s) or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated have the right to request a Fair Hearing in accordance with N.J.A.C. 10:49-10.3. The New Jersey Department of Health and Senior Services provides written notice to such individuals regarding their clinical eligibility for Nursing Facility Level of Care and services under the program, whereas the County Welfare Agency (identified as the Board of Social Services, the Welfare Board, the Division of Welfare, or the Division of Social Services) provides written notice to individuals regarding financial eligibility. A Participant/Legal Representative, who is denied Medicaid services, as defined by N.J.A.C. 8:85 or N.J.A.C. 8:86, as not meeting Level of Care, is informed of his or her right to a Fair Hearing by the Community Choice Counselor, who has completed the Level of Care/Comprehensive Evaluation. The individual is given a denial letter in person or via mail at the time of the outcome of the evaluation and/or within 24 hours following completion of the evaluation. The Counselor explains the denial process and has the participant verbalize his or her understanding of the same. The Counselor will counsel the participant on alternative options and services. If a participant's legal representative is to be notified and if he or she is not present at the time of the evaluation he or she receives a phone call from the Counselor and is provided written notice via mail in the form of the denial letter, explanation of the denial process, and is counseled as to alternative services.

All written notices specify that individuals have 20 days from the date of the denial letter/or letter to reduce, change, suspend, or terminate services to submit a request for a Fair Hearing to the Division of Medical Assistance and Health Services' Office of Legal and Regulatory Compliance, Fair Hearing Unit and provide the applicant with the address of the Fair Hearing Unit. The denial letter contains instructions that outline the participant's right to represent himself or herself, designate a non-attorney representative, or to have legal counsel. Further, the notices provide the contact information for a New Jersey legal services agency(ies) that provides legal services to lower income individuals.

Written notices inform the individual of the following: "If you have been receiving Medicaid benefits and request a fair hearing within the 20-day period, your Medicaid benefits may continue until a hearing decision is reached so long as you remain eligible in all other respects. However, if the Fair Hearing decision is not in your favor, you may be required to repay any Medicaid benefits to which you were not entitled." Because of the potential responsibility to repay the state for Medicaid benefits for which the person was not entitled during the Fair Hearing process, the participant is offered the choice to continue to receive the benefits or not. This choice is included on the notice that informs the individual of the right to request a Fair Hearing and states the following: "If you are requesting a Fair Hearing for Medicaid benefits that you are currently receiving, check one:

Continue my Medicaid benefits during the fair hearing process. I understand that if the fair hearing decision is not in my favor that I may be required to repay any Medicaid benefits I was not entitled to receive.

Do not continue my Medicaid benefits during the fair hearing process."

Adverse notices (denial letter) of clinical ineligibility are maintained in the participant's file in the Regional Field Office of Community Choice Options. Notices of Adverse Actions and the opportunity to request a Fair Hearing that are sent by the County Welfare Agencies (financial ineligibility) are kept in the participant file at the County Welfare Agency.

Participants/Legal Representatives have the right to request another evaluation to determine clinical eligibility if there has been change in condition or circumstance.

Once the participant/Legal Representative requests a Fair Hearing, the Office of Administrative Law then schedules the time, place, and date of the Hearing.

The Office of Administrative Law has the jurisdiction of the case for docketing, adjournment, plenary (full hearing) and initial decision in accordance with N.J.A.C. 10:49-10.3.

Pursuant to a Memorandum of Understanding (Interagency Agreement) by and between the New Jersey Department of Human Services ("DHS") and the New Jersey Department of Health and Senior Services ("DHSS") dated September 18, 1996, the Department of Human Services, in consultation with the Department of Health and Senior Services, is responsible for the Fair Hearing process. All requests are processed through the Division of Medical Assistance and Health Services, Office of Legal and Regulatory Affairs, Fair Hearing Unit and transmitted to the New Jersey Office of Administrative Law (OAL).

NOTE: A program participant will not receive a written notice providing Fair Hearing rights when a provider implements service reductions due to Staff shortages, etc. that were not initiated by the Department of Health and Senior Services or the County Welfare Agency. However, the participant's Care Manager will work with the participant and the provider in an attempt to reach a compromise on the provision of a service or the amount of service provided.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

No. This Appendix does not apply

Yes. The State operates an additional dispute resolution process

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



Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

No. This Appendix does not apply

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

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

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

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

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

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

- Reports of abuse, neglect and exploitation of Waiver participants living in the community in a non-Assisted Living or Adult Family Care setting are reported to an Adult Protective Services (APS) agency. There is an Adult Protective Services program in each of the 21 counties. The types of incidents reported to Adult Protective Services are based on the definitions from regulations. "Abuse" means the willful infliction of physical pain, injury or mental anguish, unreasonable confinement, or the willful deprivation of services, which are necessary to maintain a person's physical and mental health. "Neglect" means an act or failure to act by a vulnerable adult or his caretaker that results in the inadequate provision of care or services necessary to maintain the physical and mental health of the vulnerable adult, and which places the vulnerable adult in a situation which can result in serious injury or which is life-threatening. "Exploitation" means the act or process of illegally or improperly using a person or his resources for another person's profit or advantage. Any professional, including Care Managers, Care Management Supervisors, and Care Coordinators is obligated to report incidents of abuse, neglect and exploitation. N.J.S.A. 52:27-7
The method of reporting of abuse, neglect, and exploitation to Adult Protective Services is through phone, written form, fax, and a web-based reporting system.

NJ state law requires: (1) A health care professional, law enforcement officer, firefighter, paramedic or emergency medical technician who has reasonable cause to believe that a vulnerable adult is the subject of abuse, neglect or exploitation to report the information to the county adult protective services provider. (2) Any other person who has reasonable cause to believe that a vulnerable adult is the subject of abuse, neglect or exploitation may report the information to the county adult protective services provider.

The Division of Aging and Community Services (DACS) works in collaboration with Staff from the 21 County Area Agencies on Aging and their approved subcontractors, and surveyors from the State Division of Health Facilities Evaluation and Licensing (HFEL) to oversee the quality of care in Assisted Living Residences (ALR), Comprehensive Personal Care Homes (CPCH), Assisted Living Programs (ALP) in Subsidized Housing, and Adult Family Care (AFC) settings. During the routine biennial licensing visits conducted by State HFEL surveyors:

- Regulatory Staff reviews the file of an least one Waiver beneficiary in each facility and also interviews the participant to determine health status, adequate evaluation of the individual's needs, sufficiency of the General Service Plan (Plan of Care) to meet the assessed needs, verification of service delivery, and degree of satisfaction with the care.
- Regulatory Staff promptly notifies the Division of Aging and Community Services, electronically, when they impose penalties or curtailments on a facility due to deficiencies.
- Health Facilities Evaluation and Licensure requires a plan of correction for deficiencies identified. The Plan of Correction is reviewed by Health Facilities Evaluation and Licensure Staff and approved when the deficiency is corrected. The facility may be revisited to confirm compliance with the Plan.
 - o When enforcement is necessary, penalties may be levied and may also require a directed plan of correction, which usually requires hiring an outside consultant to assist in correcting the problems.

Health Facilities Evaluation and Licensure sends the DACS County Liaison Supervisor copies of the AL facility inspection reports for each provider with the name and Medicaid number for each inspection report and subsequent penalty letter(s). The DACS County Liaison Supervisor then gives this information to the applicable DACS County Liaison/Quality Assurance Specialist for follow up with the Care Manager for each facility who will then follow up with each GO waiver participant as warranted. The electronic copies of this information received from HFEL are also posted on an internal DACS shared drive. The County Liaison/Quality Assurance Specialist contacts the Care Manager who provides service to Medicaid Waiver participants in the AL facility as forewarning of past problems so that he or she can focus on that area in future contacts/visits with the Waiver participant.

Health Facilities Evaluation and Licensure surveyors and/or the Office of the Ombudsman for the Institutionalized Elderly (OOIE), in the Division of Elder Advocacy, Department of Public Advocate investigates complaints of neglect, abuse or exploitation in Assisted Living or Adult Family Care. Each complaint made to the Office of the Ombudsman for the Institutionalized Elderly is addressed individually and resolved or referred to the proper authority for further action. The Office of the Ombudsman for the Institutionalized Elderly has the jurisdiction to levy fines, refer perpetrators to the County Prosecutor for criminal prosecution, or the appropriate licensing board for disciplinary action.

The DACS Office of Long-Term Care Programs' Quality Assurance Unit has developed a Critical Incident Report form and policy requiring the reporting of incidents that could have a negative impact on the Waiver participant's health and welfare. In July 2008, DACS issued a Critical Incident Report Policy which applies to those Care Managers who serve individuals in the Community as well as those in Assisted Living and Adult Family Care settings. The policy instructs the Care Manager to use the Critical Incident Report Form to notify the applicable DACS County Liaison within one business day of the Care Manager's report to Adult Protective Services (APS) about any report of abuse, neglect or exploitation or within one business day of learning of an incident that poses additional risks to the Waiver participant's health and safety. A web-based database to collect this information is maintained for DACS.

The Care Management Supervisor or County Care Coordinator may serve as an alternate critical incident reporter if the Care Manager is unable to report critical incidents. The DACS Quality Assurance Unit's critical incident reporting policy is broader than Adult Protective Services reporting and, in addition to reports made to Adult Protective Services, will include such incidents as criminal events not reported to Adult Protective Services, serious injury, death other than by natural causes, the need to use back up plans, and other events that cause harm to an individual such as elopement from a facility, facility closure or loss of home.

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

1. Trainings & Education from Adult Protective Services and the DACS Office of Long-Term Care Programs Information on abuse, neglect and exploitation is furnished to the public through trainings given to various groups associated with vulnerable citizens, their caregivers, Care Managers and public or private Staff that work with the vulnerable. Brochures were distributed throughout the State describing Adult Protective Services and the services provided over the last several years. Brochures are periodically sent to various agencies that work with the vulnerable, such as senior centers, nutrition sites, Area Agencies on Aging, and County Welfare Agencies.

- Entity responsible for Training & Education:

The Adult Protective Services State Coordinator and Adult Protective Services Provider Agency supervisors offer ongoing trainings Statewide throughout the year. The trainings are offered to the public, professionals, case managers, hospital and nursing home Staff and any other entity that is involved with frail adults. The Office of the Adult Protective Services State Coordinator is responsible for updating the brochures for Statewide distribution.

- Care Managers receive Adult Protective Services trainings in their county through Adult Protective Services or trainings through the Division of Aging and Community Services (DACS).
- o Care Managers attend Core Care Management training provided by the Division of Aging and Community Services. Information on abuse, neglect, exploitation, and Adult Protective Services is presented in one of the sessions.
- o Periodic training on Adult Protective Services and other resources for the prevention of abuse, neglect or exploitation is offered to all Care Managers.

Global Options Care Managers educate participants and/or caregivers on Adult Protective Services' services on a case-by-case basis during the initial visit, through their monthly or quarterly contacts, or referrals to other agencies.

The DACS Quality Assurance Unit's policy on critical incident reporting, effective July 2008, ensures that participants/families will be given information about how to notify appropriate authorities or entities in the case of abuse, neglect or exploitation. The policy requires that written information be distributed to participants, with participants signing to indicate that information was received and explained. A copy of the documentation is kept in the participant's file.

Trainings and Education from Office of the Ombudsman for the Institutionalized Elderly (OOIE)

The jurisdiction of the State's Office of the Ombudsman for the Institutionalized Elderly gives it power to oversee and protect individuals in institutionalized settings, including Assisted Living Facilities/Programs and Adult Family Care Homes, when necessary. However, the long term goal is to promote and advocate for the empowerment of individuals and their families so they can achieve greater self-determination. The State Department of the Public Advocate maintains a website that covers such topics as: How to Report a Concern; Consumer Information (Helpful Advice for Seniors and Families; Nursing Home Bill of Rights and Reports Cards; and New Laws that affect individuals in Assisted Living/Adult Family Care or Nursing Homes. The Department publishes monthly updates on topics of interest for the public and the Office of the Ombudsman for the Institutionalized Elderly makes Staff available to present in-service educational programs on a variety of care-related topics. The Department launched an education campaign in 2007 targeted at educating older New Jerseyans, their families, and nursing facilities about basic legal issues. The campaign focuses on the appropriate use of a power of attorney, and how individuals can ensure that they maintain decisions making authority about their own lives. Department staff conducts training sessions in nursing facilities and senior centers throughout the state. The Department also provides consumer education materials about the use of a power of attorney on its web site: <http://www.state.nj.us>

The Department of the Public Advocate's Division of Elder Advocacy presents numerous trainings on many topics including Office of the Ombudsman for the Institutionalized Elderly, Power of Attorney and General long-term care information. The Office of the Ombudsman for the Institutionalized Elderly also conducts in-service training sessions for facility staff about the Office, its mandate, incident updates, and how to report a suspected incident of abuse, neglect or exploitation.

The Department of Health and Senior Services' Division of Aging and Community Services (DACS) hosts quarterly meetings for the County Care Coordinators and Care Management Site Supervisors and six Regional Care Management Meetings with the Care Managers twice a year to provide clarification on recently issued/revised policies and procedures such as: the Critical Incident Policy, Plan of Care Development, identifying potential risks and the need for back-up plans, the availability of Special Medical Equipment, and Quality Assurance Reports.

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

Critical incidents or events are reported to the particular county Adult Protective Services office, or to the State's Public Awareness, Information, Assistance and Outreach Unit toll-free number. Other sources that receive calls include the Adult Protective Services State Coordinator's office, the Department of Health and Senior Services, Division of Aging and Community Services, Department of the Public Advocate, and the Governor's Office.

The county Adult Protective Services Provider Agency is responsible for evaluating reports. Reports are evaluated based on the definitions of a vulnerable adult, abuse, neglect and exploitation as defined in statute and regulations (NJSA 52:27 D-406 et seq). Reports are substantiated when the preponderance of evidence supports the allegation.

The county Adult Protective Services supervisor assigns an Adult Protective Services worker to the investigation. An Adult Protective Services investigation is a thorough evaluation of a potential at-risk adult. A face-to-face meeting with the adult by a trained Adult Protective Services Social Worker is required. During this meeting the potential client is interviewed in private. Every effort is made to determine the competence of the adult. Other individuals or

agencies that have knowledge of the situation may also be interviewed. An interview with the alleged perpetrator will be arranged, if applicable. The evaluation may include a review of social, medical, and financial records.

The Adult Protective Services Provider Agency conducts an evaluation of the client within 72 hours of receiving the referral unless there are indications of immediate physical harm or clear and substantial risk of death, which then requires an immediate evaluation. If the referral is substantiated during the evaluation, the client would be taken to the hospital, if warranted, or the incident reported to law enforcement. Reports not requiring immediate evaluation require a face-to-face contact within 3 working days. The Adult Protective Services worker has 30 days to make a determination of the substantiation of the report and to complete the Client Evaluation Form, which is entered into a database.

When the investigation is complete a report is submitted to the Adult Protective Services Supervisor who consults with the Social Worker and determines if the adult is at risk of abuse, neglect or exploitation. All information generated by the investigation is confidential. The Adult Protective Services worker will work closely with the client to ensure the client is safe, the risk is removed, and if necessary, services in place. Because of confidentiality mandated by the Adult Protective Services statute (NJSA 52:27 D – 406 et seq.), the only investigation results that are shared with agencies are information that is needed for that specific provider/agency to deliver services, e.g., medical information may be given to a Visiting Nurse Agency that is providing services to the client. A court order is necessary to make the case file public.

When a Critical Incident is reported to the DACS Office of Long-Term Care Programs' Quality Assurance Unit, the County Liaison/Quality Assurance Specialist staff is responsible to respond to the Care Manager within two business days, gather additional information as necessary, track the status of the incident with the Care Manager, and remain involved to offer direction, instructions, and intercession until the situation is resolved.

The Division of Aging and Community Services works in collaboration with surveyors from the Division of Health Facilities Evaluation and Licensing to oversee the quality of care in Assisted Living facilities, Assisted Living Programs, and Adult Family Care. Surveyors audit Assisted Living facilities, Assisted Living Programs, and Adult Family Care prior to licensure and every two years thereafter. They also audit in response to complaints and during any necessary follow-up visits.

The Division of Health Facilities Evaluation and Licensing sends copies of deficiency and enforcement letters to the Division of Aging and Community Services Supervisor, which are posted to a shared drive, shared with applicable Staff and forwarded to the Care Managers who serve the participants that reside in the cited facility or are enrolled in the cited Assisted Living Program or Adult Family Care.

Complaints for all Long Term Care (LTC) Facilities are investigated by the Complaints Program. Complaints are triaged according to the severity of the allegations made. Complaints alleging Immediate Jeopardy are investigated within two working days. Complaints alleging harm are investigated within 10 working days. Other complaints are investigated within 3 to 6 months. The actual investigation usually is completed in one or two days. The finalization of the investigation process is usually completed within six weeks from the date of the investigation.

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

The Division of Aging and Community Services has established a central registry for the receipt and maintenance of all reports of suspected abuse, neglect and exploitation of vulnerable adults. The Adult Protective Services State Coordinator oversees this database. The Adult Protective Services client data is sent electronically in a Secure File Transfer Protocol by the county Adult Protective Services agency to the State coordinator. In the future, the information will be collected through a web-enabled database with the ability to collect reports at any time.

The Adult Protective Services State Coordinator provides oversight of the county Adult Protective Services agencies through annual monitoring of the agency for compliance and intervention when complaints are registered.

At present, the Adult Protective Services State Coordinator reviews the data monthly and completes a trend analysis quarterly. Results of the trend analysis for underserved populations will be used for public awareness and Staff training.

In Fall 2006, the APS database was altered to collect information on APS participants involved in the long-term care Waiver programs operated by DACS. At that time, the APS State Supervisor was working with a small database, though it was growing daily. The information applicable to the GO Medicaid Waiver can only be found at the time of termination of the APS case. The terminations typically are not for at least 90 days after the APS referral is made. In

November 2009, the APS State Supervisor ran a preliminary report, based on 2,255 terminated cases. It is important to note that the field applicable to APS participants involved in long-term care Waiver programs, as used to generate this report, is not a mandatory field used by APS workers since many APS clients may not be aware of the program they are enrolled in. It is usually the APS agency that recognizes the Waiver program/services as instrumental to keeping the individual independent in the community. In 2009, an updated APS report was created for the DACS Quality Assurance Unit which contains an increased amount of information including the Substantiated Type of Abuse and the Resolution of the APS Investigation. The report covers time periods requested by the DACS Quality Assurance Unit staff for their review. The newer report captures additional information to make it more useful for reporting purposes. Adult Protective Services in New Jersey is not permitted by law to disclose these individual's names in this report. Also, by statute any referrals to APS are for problems which occurred in the community (non-licensed, home settings) so a column indicating the place where the abuse occurred is not necessary.

o This report is sent to the DACS Quality Assurance Unit for review. The DACS Quality Assurance Unit uses this report:

- for follow-up actions, if necessary,
- to foster communication between Adult Protective Services and the Care Management agencies at the local level,
- to target topics for training.

The DACS Critical Incident Report policy requires the reporting to the Office of Long-Term Care Programs' Quality Assurance Unit incidents that could have a negative impact on the Waiver participant's health and welfare. The Care Manager is to report the incident to the DACS County Liaison/Quality Assurance Specialist within one business day of a report to APS/Office of the Ombudsman for the Institutionalized Elderly (for those in Assisted Living or Adult Family Care) or of learning of the incident. The County Liaison/Quality Assurance Specialist is responsible to respond to the Care Manager within two working days of reception of the incident report to collect additional information as necessary and remain involved to offer technical advice. The Care Manager creates a follow-up report, if necessary, to advise DACS of the final resolution of the situation. The County Liaison/Quality Assurance Specialist completes a standardized form to summarize the Care Manager's report of the incident, including resolution and state comments as applicable. A web-based database collects this information.

This Critical Incident reporting system is broader than Adult Protective Services reporting and, in addition to reports of abuse, neglect and exploitation, includes reports of incidents such as elopement from a facility, facility closure or loss of home and failure of back-up plans.

Appendix G: Participant Safeguards

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

a. Use of Restraints or Seclusion. *(Select one):*

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

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

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

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

The Standards for Licensure, N.J.A.C. 8:36-4.1 (a) 17 States that each resident is entitled to the right to be free from chemical and physical restraints, unless a Physician, Advanced Practice Nurse, or Physician Assistant authorizes the use for a limited period of time to protect the resident or others from injury. Under no circumstances shall the resident be confined in a locked room or restrained for punishment, for the convenience of the facility Staff, or with the use of excessive drug dosages.

The Standards for Licensure, N.J.A.C. 8:36, for Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs address the use of restraints generically and in general for residents of the Assisted Living Residences and Comprehensive Personal Care Homes. N.J.A.C. 8:36-21.2 and 8:36-22.2 State that: a) The facility shall develop policies and procedures that support a restraint-free environment for all residents. b) The use of any restraining device shall be based on an evaluation and shall require a Physician, Advanced Practice Nurse or Physician Assistant order. c) The least restrictive device shall be used, in compliance with the prescriber's order. d) A specific Plan of Care shall be developed for the use of any restraining device.

Orders for restraints must go from least restrictive to most restrictive. The regulations do not speak to "alternatives" to restraints. The facility Plan of Care must be followed if a restraint/restraints are in use in the facility. Any assessments, including assessments for the use of restraints must be recorded in the resident record. New Jersey requires a Plan of Care to be developed by the facility Registered Nurse, which identifies the type of restraint to be used. Specific order/prescription for the use of restraints must be in the resident's record.

The Assisted Living Regulations do not specifically address safeguards for each type of restraint. The Surveyors rely on the assessment by the Registered Nurse for the need for a safe use of restraints in addition to an order from the resident's physician.

N.J.A.C. 8:36-5.6 (b) states that "The facility or program shall maintain and implement a staff orientation and a staff education plan, including plans for each service and designation of person(s) responsible for training. All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, the following: Resident rights, Abuse and neglect, Pain management, and the care of residents with Alzheimer's and related dementia conditions." The survey staff reviews sample records of staff qualifications, including trainings and the use of restraints, during the licensure surveys. Any lack of training for the use of restraints would be included as a deficiency. Surveyors stated that they have never seen a "seclusion" room in any Assisted Living Facility in New Jersey. N.J.A.C. 8:36-21.2 and 8:36-22.2 prohibit the use of seclusion.

Surveys are unannounced; facility staff does not know when a survey will occur. During the survey, Surveyors tour the facility unannounced to make observations regarding any use of restraints in the facility. If a restraint is observed, Staff interviews are conducted to determine the way the restraint is used and to identify Staff's knowledge regarding safe use of the restraint. The medical record for any resident using restraints is reviewed to ensure appropriate and specific orders for their use are in place, that the resident has been assessed for the safe use of restraints and that a care/service plan has been developed to direct Staff in the specific use guidelines.

Restraints or Seclusion are not permitted in the Adult Family Care program or the Assisted Living Program. A spot check that revealed their usage would be a violation of regulation and/or policy and would be a cause of a deficiency that requires a plan of correction.

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

The Division of Health Facilities Evaluation and Licensing (HFEL) in the Department of Health and Senior Services is responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed. The oversight is conducted during unannounced licensure surveys, investigations in response to a complaint, revisits as follow-up to previous surveys and monitoring surveys.

Although restraint use has not been observed as a common practice in New Jersey's Assisted Living facilities, survey methods identified in the above answer would correlate to this question as well. New Jersey's survey process has not identified trends or patterns of restraint use in New Jersey Assisted Living facilities and as a result, nor have there been identification of "incidents" or negative outcomes related to their use.

Surveyors from the Health Facilities Evaluation and Licensing (HFEL) Division attested to the fact that they have never seen a "seclusion" room in any Assisted Living Facility in New Jersey. N.J.A.C. 8:36-21.2 and 8:36-22.2 prohibit the use of seclusion.

During the entrance conference in the ALR, Surveyors ask the facility to identify any Medicaid Waiver participants in the residence and facility staff also must identify any resident with any type of restraint. Medicaid residents are always added to the survey staff's sample residents during regularly scheduled inspections.

HFEL provides quarterly updates upon request at various meetings and trainings, such as Assisted Living Licensing Workgroup meetings, of which DACS Quality Assurance Unit staff members participate, on related topics such as the 10 most common deficiencies found during HFEL surveys. Use of restraints has never been included in the reports because since new regulations were promulgated in February 2007, there has not been one deficiency cited for improper use of restraints.

Appendix G: Participant Safeguards

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

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

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

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

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

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

Assisted Living Facilities may establish programs to meet the needs of residents with Alzheimer's disease or other dementias. Such programs shall provide individualized care based upon evaluation of the cognitive and functional abilities of Alzheimer's and dementia residents who have been admitted to the program. A facility that advertises or holds itself out as having an Alzheimer's/dementia program shall, pursuant to N.J.A.C. 26:2M-7.1, provide a member of the public seeking placement of a person diagnosed with Alzheimer's and/or related disorders in the facility with a clear and concise written list that indicates the safety policies and procedures and any security monitoring system that is specific to residents diagnosed with Alzheimer's and related disorders. An Assisted Living Facility with an advertised Alzheimer's/related disorders unit is permitted to secure the unit with an alarm system, doors that require codes to exit, or Wanderguard systems.

The safeguards concerning the use of restrictive interventions include: Checking to see that orders for specific, least restrictive devices exist and are used first; Confirm Physician, Physician Assistant or Advanced Nurse Practitioner orders for specific use of restrictive devices; Confirm care planning to direct Staff in safe and specific use of restraints (when, where, how, how long); and Order and care planning. Evaluation for use and evaluation of use with follow up interventions as needed.

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

Department of Health & Senior Services (DHSS), Division of Health Facilities Evaluation & Licensing (HFEL) is responsible for monitoring and overseeing the use of restrictive interventions for Adult Day Health facilities (Adult Day Health Services) and Home Health Agencies. The State prohibits the use of restraints in these settings unless there is a physician's order to use restraints to protect self or others from harm. Adult Day Health facilities post a "Participant's Rights" sheet in all the languages of the participants attending Adult Day Health. This sheet documents the policy on restraints in Adult Day Health. Each participant signs that he/she received a copy.

Methods of detecting the use of restraints while conducting a survey include: tour, observations and interviews. Observations and record reviews are made to confirm that appropriate orders exist and that evaluations and care planning have been completed.

Facilities and participants receiving Home Health Agency services at home are surveyed routinely to ensure all applicable State requirements are followed.

Reports of abuse on using restraints are made to the Complaints Department of Health Facilities Evaluation and Licensure. Investigators are sent to the home or facility to investigate the incident. If the incident is substantiated, the facility or agency is given a deficiency and must develop a Plan of Correction to address the incident.

Health Facilities Evaluation and Licensure sends the DACS County Liaison Supervisor copies of the AL facility inspection reports for each provider with the name and Medicaid number for each inspection report and subsequent penalty letter(s). The DACS County Liaison Supervisor then gives this information to the applicable DACS County Liaison/Quality Assurance Specialist for follow up with the Care Manager for each facility who will then follow up with each GO waiver participant as warranted. The electronic copies of this information received from HFEL are also posted on an internal DACS shared drive. The County Liaison/Quality Assurance Specialist contacts the Care Manager who provides service to Medicaid Waiver participants in the AL facility as forewarning of past problems so that he or she can focus on that area in future contacts/visits with the Waiver participant.

Department of Health & Senior Services (DHSS), Division of Health Facilities Evaluation & Licensing (HFEL) is responsible for monitoring and overseeing the use of restrictive interventions for Assisted Living Facilities, Comprehensive Personal Care Homes Assisted Living Programs. Semi annual surveys are conducted at these facilities to detect the unauthorized use of restrictive interventions. Also the state utilizes a progressive enforcement process (fines, directed plan of correction, temporary management, termination) to deter facilities from the unauthorized use of restrictive interventions.

The Division of Health Facilities Evaluation and Licensing (HFEL) in the Department of Health and Senior Services is responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed. Quarterly Work Group Meetings are conducted between the division and the facility Long Term Care Organizations. As part of these meetings, statistics for deficiencies cited are summarized, analyzed for frequency and causality and strategies for reduction are formulated. Data that indicated the unauthorized use of restrictive interventions would be subject to this review.

Department of Health & Senior Services (DHSS), Division of Health Facilities Evaluation & Licensing (HFEL) is responsible for monitoring and overseeing the use of restrictive interventions for Adult Day Health facilities and Home Health Agencies. Semi annual surveys are conducted at Adult Day Health Facilities and surveys once every 36 months are conducted at Home Health Facilities to detect the unauthorized use of restrictive interventions. Also the state utilizes a progressive enforcement process (fines, directed plan of correction, temporary management, termination) to deter facilities from the unauthorized use of restrictive interventions.

Appendix G: Participant Safeguards

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

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

a. **Applicability.** Select one:

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

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

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

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

Medication administration is authorized in the Assisted Living Residence (ALR), Comprehensive Personal Care Home (CPCH), Assisted Living Program (ALP), and in the Adult Family Care Home. For Assisted Living, the administration of medications is within the scope of practice and remains the responsibility of the Registered Nurse. The Registered Nurse may choose to delegate the task of administering medications in accordance with NJAC 13:37-6.2 to certified medication aides. According to NJAC 8:36-1.3: Medication administration means a procedure in which a prescribed medication or biological is given to an Assisted Living resident by an authorized individual in accordance with all laws and regulations governing such procedures. The complete process of administration includes: Removing an individual dose from a previously dispensed, properly labeled container (including a unit dose or unit-of-use container); verifying it with the prescriber's orders; giving the individual dose to the resident; seeing that the resident takes it (if oral); and recording the required information, including but not limited to the method of administration, time administered, initials of individuals who administered the medication, and effect of the medication when "PRN" or as-needed medications are administered.

Regulation NJAC 8:36-11.5 states that:

- a) The delegating nurse shall review with the certified medication aide medication actions and untoward effects for each drug to be administered. Pertinent information about medications' adverse effects, side effects, contraindications, and potential interactions shall be incorporated into the Plan of Care for each resident, with interventions to be implemented by the personal care assistant and other caregiving Staff, and documented on the Medication Administration Record (MAR).
- b) The certified medication aide shall contact the Registered Nurse for any questions or clarification regarding medication administration.
- c) At least weekly, a Registered Nurse shall review and sign off on any modifications or additions to the Medication Administration Record that were made by the certified medication aide under the Registered Nurse's delegation.

The facility Registered Nurse is responsible to review the medication regimen for all residents in the Assisted Living facility. If a Certified Medication Aide program is in place, the Registered Nurse is responsible for all delegations of medication administration to the residents and observations, skills testing and ongoing in-service education of the Certified Medication Aide Staff. A Consultant Pharmacist is required to conduct quarterly drug regimen reviews.

The Registered Nurse shall report medication errors and adverse drug reactions immediately to the prescriber, to the provider pharmacist and/or consultant pharmacist, and shall document the incident in the resident's record.

N.J.A.C. 8:36-11.3 states: (a) If indicated in the resident's health service plan or resident's general service plan, a designated employee shall provide resident supervision of self-administration of medications in accordance with physicians' orders. Any employee who has been designated to provide resident supervision of self-administration of medications shall have received training from the Licensed Professional Nurse or the licensed pharmacist, and such training shall be documented.

1. The facility or program shall document the provision of training to each employee who has been designated to provide resident supervision of self-administration of medications;
2. The facility or program shall document any instance where medications are not taken in accordance with the prescriber's orders; and
3. The facility shall keep a record of all prescribed medications for which the resident is receiving supervision of medication administration.

Regulations require that surveys of facilities be conducted every 24 months to confirm compliance with all regulations, including those that address medication administration, management and follow-up.

In Adult Family Care (AFC), the licensed Sponsor Agency's Registered Nurse may delegate medication administration to an approved Adult Family Care Caregiver who has completed a 30 hour Medication Administration Training course and demonstrated the adequacy of his or her knowledge, skill and competency to perform the task being delegated (NJAC 13:37-6.2(d)). In training the Caregiver to administer medications, the course emphasizes that the Caregiver and the delegating Registered Nurse must maintain close communication. There are numerous professional judgments and decisions that must be made in relation to the medication administration task; only the Registered Nurse has the expertise and authority to make such

judgments and decisions, in consultation with the participant's Health Care Provider and Pharmacist.

The caregiver is seen in the community as surrogate family and, as such, may have an occasion to interact with a health care professional about a non-emergency issue with regard to the participant's care. Reports of these contacts will be documented in a caregiver's progress notes. In the case of a medication change due to a change in participant's condition, the caregiver must report the change to the Registered Nurse before the medication is given. The Sponsor Agency shall have at least one Registered Nurse available at all times. Available shall mean on call and capable of making a home visit as necessary. The Registered Nurse will make a judgment whether to visit the caregiver to instruct EXCEPT in the case of a change of route or start of insulin injections and then the Registered Nurse must visit within 24 hours or before the caregiver administers the insulin. The Sponsor Agency's Registered Nurse provides additional training to the caregiver based on the specific needs of an Adult Family Care participant at the time the specific need is identified.

The Sponsor Agency's Registered Nurse and/or Social Worker/Care Manager visit the participant and caregiver monthly and review the Plan of Care and Caregiver's progress notes, with particular attention to any medication comments.

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

NJAC 8:36 :11 details the requirements of an Assisted Living Facility/Program re: qualifications of Pharmacists, provision of pharmaceutical services, supervision of medication administration, administration of medications, required instruction for a Certified Medication Aide, required documentation of administered medications, Certified Medication Aide program, designation of a Pharmacist, and storage and control of medications to ensure that medications are managed appropriately.

The Department of Health and Senior Services or its designee, per NJAC 8:43E-2.1, is responsible for oversight of Medication Administration in Assisted Living and may conduct periodic or special inspections of licensed health care facilities (including Assisted Living Facilities and Programs) to evaluate the fitness and adequacy of the premises, equipment, personnel, policies and procedures, and finances, and to ascertain whether the facility complies with all applicable State and Federal licensure regulations and statutes. The Department may conduct a survey of a facility upon the receipt of complaint or allegation by any person or agency, including a patient, his or her family, or any person with knowledge of the services rendered to patients or operations of a facility. During a survey, the Department may evaluate all aspects of patient care, including the inspection of medical records, observation of patient care where consented to by the patient, inspection of all areas of the physical plant under the control or ownership of the licensee, and interview the patient or resident, his or her family or other individuals with knowledge of the patient or care rendered to him or her. The Department also surveys Assisted Living Residences, Comprehensive Personal Care Homes, Assisted Living Programs and Adult Family Care Sponsor Agencies annually, during a follow-up visit to a previous survey, or for monitoring purposes. It is during surveys that medication administration records are reviewed. If information indicating a potential risk to patient safety is discovered or licensing regulations have been violated, a deficiency may be cited by the Department, a Plan of Correction required, or enforcement remedies are imposed.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

- ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers

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

Policies that apply to the administration of medications by Waiver providers to individuals unable to self-administer and the responsibilities of providers for overseeing self-administration are summarized in G-3 b.i. NJAC 8:36 -11.3, Supervision of medication administration, states: If indicated in the resident's health service plan or resident's general service plan, a designated employee shall provide resident supervision of self-administration of medications in accordance with physicians' orders. Any employee who has been designated to provide resident supervision of self-administration of medications shall have received training from the licensed professional nurse or the licensed pharmacist, and such training shall be documented. The facility or program shall document the provision of training to each employee who has been designated to provide resident supervision of self-administration of medications. The facility or program shall document any instance where medications are not taken in accordance with the prescriber's orders. The facility shall keep a record of all prescribed medications for which the resident is receiving supervision of medication administration."

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

Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).

Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the State:

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.

Specify the types of medication errors that providers are required to record:

It is required by N.J.A.C. 8:36-11.6 (e) that the nurse report medication errors to the prescriber, provider pharmacy and/or consultant pharmacist.

In the reportable events regulation, 8:36-5.10 (a) 2 requires that facilities report to the Department of Health and Senior Services (Department) "Any major occurrence or incident of an unusual nature, including, but not limited to all fires, disasters, elopements, and all deaths resulting from accidents or incidents in the facility or related to facility services. Reports of such incidents shall contain information about injuries to residents and/or personnel, disruption of services, and extent of damages." The Registered Pharmacist interprets this regulation to require reporting medication errors, in writing, that result in harm to the patient. The written notification to the Department shall be forwarded to: Director, Office of Certificate of Need and Healthcare Facility Licensure, New Jersey State Department of Health and Senior Services.

The Registered Nurse is required to record any medication errors and adverse drug reactions. Medication errors could include the following: Medication prescribed for one resident is administered to another; medications are given in the wrong dose to an individual; medications are administered with the wrong

- frequency; the wrong medication is administered to an individual; medications are not administered at all; or medications are administered by personnel not trained, licensed or certified to do so.
- iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Department of Health and Senior Services, Division of Health Facilities Evaluation and Licensing, is responsible for monitoring the performance of Waiver providers in the administration of medications to Waiver participants. It does this by conducting unannounced surveys of Assisted Living Residences, Comprehensive Personal Care Homes, Assisted Living Programs and Adult Family Care Sponsor Agencies routinely, and/or in response to a complaint, follow-up to a survey, or to monitor performance.

Medicaid Waiver participants are included in each unannounced standard survey conducted at a facility that participates in the Medicaid Waiver program. During survey, Staff evaluates the services provided to the residents including the administration of medications.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Number and percent of GO participants that have Quarterly Visits conducted and documented in their Monitoring Record as maintained by their care management agency.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

<input checked="" type="checkbox"/> Other Specify: Care Management Supervisors	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from Care Manager, opened during past 3 years, calculating sample size with Confidence Interval of 5; Confidence Level 95%, population of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of participant records are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

Performance Measure:

Number and percent of GO participants' Monitoring Records that include documentation that services arranged are addressing their health status and activities of

daily living (ADL) care needs.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Care Management Supervisors	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from Care Manager, opened during past 3 years, calculating sample size with Confidence Interval of 5; Confidence Level 95%, population of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of participant records are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

Performance Measure:
Number and percent of Plans of Care that document any unmet needs as assessed.

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

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Care Management Supervisors	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from Care Manager, opened during past 3 years, calculating sample size with Confidence Interval of 5; Confidence Level 95%, population of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of participant

		records are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

Performance Measure:

Number and percent of Plans of Care that address risk factors as assessed and back up plans as warranted.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Care Management Supervisors	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from Care Manager, opened during

		past 3 years, calculating sample size with Confidence Interval of 5; Confidence Level 95%, population of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of participant records are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

Performance Measure:

Number and percent of participant records with a participant-signed copy of the cover page of the GO Participant Handbook as evidence that the participant was made aware of who to contact if they suspect they are the victims of abuse, neglect or exploitation.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Care Management Supervisors	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from Care Manager, opened during past 3 years, calculating sample size with Confidence Interval of 5; Confidence Level 95%, population of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of participant records are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

<input type="checkbox"/> Continuously and Ongoing
<input checked="" type="checkbox"/> Other Specify: Every two years

Performance Measure:

Number and percent of GO waiver participants annually identified in the DACS Adult Protective Service Unit data sourced report noting APS trends on an on-going basis to identify, address and seek to prevent occurrences of abuse, neglect and exploitation.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Adult Protective Services (APS) Database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: DACs APS Unit	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Reports from the APS database for the GO staff only include those investigations for GO participants involved with APS.
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DACS APS Unit	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

Number and percent of critical incidents of GO participants reported by Care Managers to DACS staff using the Critical Incident Report system.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input checked="" type="checkbox"/> Other Specify: Care Managers and Care Management Supervisors	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
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<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

Number and percent of all Assisted Living and Adult Family Care (AL/AFC) providers that the State Division of Health Facilities Evaluation and Licensing monitors through routine biennial licensing visits.

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: DHSS Division of Health Facilities Evaluation and Licensing	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHSS Division of Health Facilities Evaluation and Licensing	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every 24 months

Performance Measure:

Number and percent of the types of reported critical incidents and the action steps taken through the Critical Incident Reporting system.

Data Source (Select one):
Critical events and incident reports
 If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

The Plan of Care developed by the participant and Care Manager indicates the participant's health and welfare needs. The Care Managers continually monitor the participant's health and welfare with monthly contacts and quarterly visits and take prompt remediation actions when needed. The Care Manager documents any changes to the participant's health and/or welfare or suspected abuse, neglect or exploitation on the Monitoring Record and contacts applicable parties to promptly address potential problems. If applicable, the Monitoring Record identifies whether a referral was made to Adult Protective Services or to any other entity for further investigation.

Plans of Care and Level of Care re-evaluations are reviewed and signed by the Care Coordinators/Care Management Supervisor to assure that services to meet participants' health and welfare needs are provided.

When problems with the Plans of Care and Level of Care re-evaluations are identified during the quality assurance reviews, the Care Manager Supervisor is alerted to the deficiencies immediately during the Exit Interview. In a Summary Letter sent by the Quality Assurance Unit as follow-up to the review, the care management agency is instructed to submit a Remediation and Improvement Plan to DACS within 30 days. All Remediation and Improvement Plan are only accepted when proof of the following is included: A) A copy of the cited document with applicable amendments attached. For document deficiencies that cannot be corrected with an amendment, a policy statement addressing how the agency will implement corrective actions in the future should be included; B) The actions to be taken (such as staff education, forms or policies to be revised) to ensure that deficiencies do not recur; C) The person(s) responsible for implementation; and D) A description of how each deficient area will be addressed in the Agency's Quality Improvement program.

Participant feedback is solicited through mass-mailed surveys every other year. DACS initiated the development of a simple, user-friendly, one-page mailed Participant Questionnaire which could be returned in a self-addressed stamped envelope and then data entered into a database so aggregate reports could be generated. The Participant Satisfaction Survey Tool gives the participants the opportunity to state if they feel they are treated with respect and questions if they know whom to contact in case they have a problem.

In addition, DACS administers the Adult Protective Services (APS) program that oversees 21 county-based APS sponsor agencies. These agencies provide services for any NJ resident who is 18 years of age or older, living in the community, has difficulty making, carrying out, or communicating decisions about their own well-being, and is subject to abuse, neglect or exploitation. Complainants may be participants, family members, formal caregivers, Care Managers, agencies or any interested individuals. An APS investigation is a thorough assessment of an individual alleged to be subject to neglect, abuse, or exploitation. Within 72 hours of a referral's receipt, a face-to-face meeting with the adult by a trained APS social worker is required. During this meeting the potential participant is interviewed in private and every effort is made to determine the competence of the adult and validity of the allegation. When the investigation is complete, a report is submitted to the APS Supervisor who then consults with the social worker and determines if the adult is subject to abuse, neglect or exploitation. All information generated by the investigation is confidential. The DACS APS Unit, does, however, maintain a database of all investigations. The APS Unit generates an annual report noting APS State trends.

In Fall 2006, the APS database was altered to collect information on APS participants involved in the long-term care Waiver programs operated by DACS. At that time, the APS State Supervisor was working with a small database, though it was growing daily. The information applicable to GQ and the Medicaid Waiver can only be found at the time of termination of the APS case. The terminations typically are not for at least 90 days after the APS referral is made. It is important to note that the field applicable to APS participants involved in long-term care Wavier programs, as used to generate this report, is not a mandatory field used by APS workers since many APS clients may not be aware of the program they are enrolled in. It is usually the APS agency that recognizes the Waiver program/services as instrumental to keeping the individual independent in the community.

b. Methods for Remediation/Fixing Individual Problems

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

In general, Care Managers are informed, and reminded periodically, as to their responsibility, as professionals, to report all incidents of suspected neglect, abuse, and/or exploitation of participants to the proper authorities. Care Managers make referrals to APS and also to the Office of the Ombudsman for the

Institutionalized Elderly (OOIE) and to the Division of Health Facilities Evaluation and Licensing (HFEL) on behalf of participants in Adult Family Care or the Assisted Living Program.

Care Managers are also responsible to report all incidents/allegations of abuse, neglect or exploitation of Waiver participants to DACS County Liaisons. DACS developed a formal Critical Incident Reporting policy and procedures in addition to a web-based tracking database to ensure that Care Managers have a systematic way to document and report incidences of abuse, neglect, and exploitation affecting GO participants to DACS staff. The State is now better equipped to aggregate, detect, and analyze statewide or regional trends and to improve the monitoring of the health and welfare of GO participants.

Assisted Living

The Division of Aging and Community Services (DACS) works in collaboration with staff from the 21 County Area Agencies on Aging and their approved subcontractors, and surveyors from the Division of Health Facilities Evaluation and Licensing (HFEL) to oversee the quality of care in Assisted Living. To facilitate the sharing of information between program and regulatory staffs about incidents that could negatively affect health and welfare of Waiver participants in Assisted Living, the Office of MIS and Data Management in DACS sends a monthly list of all Waiver participants that reside in Assisted Living Facilities to HFEL. During the annual visits:

- Regulatory staff reviews the file of an least one Waiver beneficiary in each facility and also interviews the participant to determine health status, adequate assessment of the individual’s needs, sufficiency of the Resident Service Plan (Plan of Care) to meet the assessed needs, verification of service delivery, and degree of satisfaction with the care.
- Regulatory staff promptly notifies DACS, electronically, when they impose penalties or curtailments on a facility.
 - o This information is shared with Care Managers so that they are alerted to potential problems for the participants they serve and may take actions necessary to safeguard them.
- HFEL requires a Plan of Correction for deficiencies identified. The POC is reviewed by HFEL staff and approved when the deficiency is corrected. The facility may be revisited to confirm compliance with the Plan.
 - o When enforcement is necessary, penalties may be levied and may also require a directed plan of correction, which usually requires hiring an outside consultant to assist in correcting the problems.

Typically, enforcement is determined based upon the severity of the deficiency, harm or danger to residents and whether the deficiency is a repeat. HFEL sends electronic copies of letters of enforcement to the Supervisor of the Unit that oversees the operation of the GO Medicaid Waiver. Because of confidentiality issues, HFEL is permitted to refer to the individuals on the reports with a numeric identifier only – no initials or names. GQ does not know specifically whether the enforcement actions are related to Medicaid Waiver participants, but receive the reports/letters as confirmation of a systemic problem that could have a negative impact on every resident. The letter is shared with all Division Offices that would have an interest, and forwarded electronically within two business days, to the Care Managers that serve the participants that reside in the facility and is saved on a shared drive for future reference as necessary. Follow-up discussions occur as needed.

ii. Remediation Data Aggregation

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHSS Division of Health Facilities	<input type="checkbox"/> Annually

Evaluation and Licensing	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

c. Timelines

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

No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 2)

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

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

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

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

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent

roles/responsibilities of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The following provides evidence as to the implementation of the quality management and improvement strategy. The State demonstrated through its approved Interim Procedural Guidance (IPG) that adequate and effective mechanisms for finding and resolving compliance issues on an ongoing basis are in place and where appropriate, remediation efforts and timelines for each assurance are indicated as well.
Quality Management Strategy Overview

The Quality Management Program combines Quality Assurance and Quality Improvement strategies to assure there is a system in place that continuously measures performance, identifies opportunities for improvement and monitors outcomes. Through robust system Discovery, information is gathered and analyzed to determine when there are problems and where the locus of the problem lies. Once appropriate action is taken to remedy the problem, the system of Discovery is used continuously to assure the proposed solution has been successful. Embracing the "participant-centered approach" to service provision, the New Jersey Department of Health and Senior Services and the New Jersey Department of Human Services, along with many public and private associations and service provider agencies work collaboratively with Waiver participants with a focus on his or her satisfaction and choice.

The Quality Management Program uses a five-level approach. Each level has a responsibility and an opportunity for identifying problems (Discovery), creating solutions at the provider level (Remediation) and assisting in changes in program policy (Improvement).

Level One is the Waiver participant and informal supports/caregivers. Waiver participants must have the tools needed to self-direct their services to the best of their capabilities. Waiver participants work with Waiver service providers to develop a Plan of Care that reflects personal goals and strategies to assure successful outcomes. The Quality Management Program assures that Waiver participants receive ongoing support and monitoring of their health and welfare throughout their participation in the Waiver program through: Waiver participant education and Options Counseling, Interdisciplinary Team Meetings, annual Participant Satisfaction Surveys, Critical Incident Reporting, Care Management service coordination and monitoring, on-site Quality Assurance reviews conducted by the Department of Health and Senior Services, and audits conducted by the Department of Human Services. Waiver participants play an active role in the Discovery process through communicating problems or issues to Waiver service providers. Working with Waiver service providers, Waiver participants are part of the remediation process and provide input into solutions to assure successful outcomes.

Level Two is the Waiver Care Manager and other Waiver service providers. Providers must employ self-monitoring strategies that assure that the agency's Quality Assurance and Quality Improvement policies and procedures regarding service provision to Waiver participant meet the standards of the Waiver program

(Discovery). When problems are identified, Waiver providers must evaluate whether the difficulty is staff-specific and/or related to provider-specific or programmatic policy and procedure. If the provider's own policy and procedures are the source of the problem, then the provider must assure that changes in policy and procedure are made that continue to support the Waiver participants and maintain compliance with the standards of the Waiver program. Each provider will have the tools needed to understand and measure the quality of services provision through a number of various means such as recently issued Program Instructions, Policy Memorandums, and Information Memorandums in addition to referencing past program manuals and attending regular meetings and trainings as offered by the Department of Health and Senior Services and state fiscal intermediaries.

Level Three is the Community Choice Counselor and other Office of Community Choice Options Staff. The Department of Health and Senior Services' Division of Aging and Community Services employs Community Choice Counselors who function out of three Regional Offices of Community Choice Options, directed by Field Office Managers. There is also a Global Options/Interdisciplinary Team professional in each Regional Office who serves as a specialist in assessing complex cases and developing responsive Plans of Care to assure health and welfare needs of the Waiver participants are met in a cost-effective manner and who serves as a resource and expert to Office of Community Choice Options Staff in Global Options Medicaid Waiver program operations. The State Office of Community Choice Options also employs a Regional Quality Manager who serves as a liaison to all three Regional Offices of Community Choice Options. The Office of Community Choice Options serves as a gatekeeper for the Global Options Medicaid Waiver. The Community Choice Counselor is responsible for outreach, options counseling, resource identification and referral, networking, and ultimately assuring Level of Care. The Community Choice Counselor conducts Interdisciplinary Team Meetings. Each of the three Field Office Managers, three Assistant Field Office Managers and the Regional Quality Manager compile and review data collected from the functions of the Community Choice Counselors regarding referrals and evaluations of Waiver participant in his or her region for Quality Assurance. Through these activities, the Office of Community Choice Options Staff plays an essential role in the Discovery, Remediation and Improvement processes. The Office of Community Choice Options Staff maintains regular contact with the Department of Health and Senior Services' Division of Aging and Community Services' County Liaison/Quality Assurance Specialists regarding quality management issues.

Level Four is the County Liaison/Quality Assurance Specialists (Quality Assurance Unit) and other Office of Long-Term Care Programs staff, within the Department of Health and Senior Services Staff. The Department of Health and Senior Services presently employs six County Liaison/Quality Assurance Specialists who function out of the Division of Aging and Community Services (DACS). The County Liaison/Quality Assurance Specialists act as liaisons between care management and other Waiver service providers and Department of Health and Senior Services Waiver Management Staff. In the DACS' Office of Long-Term Care Programs, Quality Assurance Unit, the County Liaison/Quality Assurance Specialists' primary responsibilities are: to ensure compliance with Federal 1915(c) Global Options for Long-Term Care Medicaid Waiver; to facilitate program effectiveness in assigned counties through quality activities such conducting participant satisfaction surveys and completing on-site Quality Assurance surveys at care management agencies; to supply technical assistance, training and consultation necessary to promote proper program implementation and to respond to customer needs; to contribute to the development and maintenance of Quality Assurance systems that promote effective operation of the Office of Long-Term Care Programs/Division of Aging and Community Services; and to provide technical assistance at the county level on issues related to Global Options and the implementation of the Aging and Disability Resource Connection processes.

The County Liaison/Quality Assurance Specialists are a vital component to the effectiveness of the Division of Aging and Community Services' Quality Management Strategy and the Office of Long-Term Care Programs' Quality Assurance Unit. For example, since May 2005, the Quality Assurance Unit has implemented Quality Assurance Visits for all care management agencies statewide. A team of 3 to 4 GQ County Liaison/Quality Assurance Specialists conducts survey reviews for each county every 24 months. Every care management agency that operates within the county is monitored during this visit, at which time the local administration of Medicaid Waiver program and care management practices are reviewed. In-depth reviews of the case records/participant files, as maintained by the Care Manager, are completed to verify a number of assurances are upheld. A standardized and electronic Participant File Review Tool is used by all surveyors and findings are exported into a database for future reporting purposes.

Sampling

During these on-site surveys, GQ County Liaisons review a sample of case records/participant files, using a stratified sampling method. When an On-site Quality Assurance Visit Notification Letter is sent, each care

management site is asked to return a list of active participants enrolled within the past three years. The sampling design calls for selecting a sample of 1 in 10 of the participants on the list. By having the lists arranged by care management site, it ensures that exactly 1/10 of the participants serviced by each care management site is selected. If a simple random sample were selected from the list, or a systematic sample from an alphabetical list, the proportion of the sample for each care management site would be subject to normal sampling variability and could be slightly higher or lower than was the case for the population being served.

In the approved Waiver, DACS used a CMS referred 'Sample Size Calculator' to compute the following parameters:

- Confidence Interval (margin of error accepted): 5
- Confidence Level Needed: 95%
- Population Size: 9,000 Enrolled Medicaid Waiver participants
- Response Distribution: 50%
- Sample Size: 369

After completing the on-site quality assurance visits since October 2006, DACS utilized this calculator again to verify DACS reviewed enough participant files in order to get results that reflect the target population as precisely as expected. DACS continues to be successful in its existing sample size determination. For example, when finding the level of precision DACS has in our existing sample, it was concluded that during Round III (QA visits occurring between October 2008- October 2009), using the confidence level of 95%, with a population of 10,082 and an actual survey of 401 participant files, the DACS confidence interval is 3.18

A number of audit tools are used by the Quality Assurance Unit to collect information and measure quality outcomes.

Survey Tools

Care Manager Questionnaire: solicits comments about care management practices, policy implementation, and suggestions for ways to make the Care Manager's role more effective.

Participant File Review: evaluates the completeness of consumer files, such as the inclusion of all core documents, Plan of Care and Level of Care comprehensiveness, thorough documentation, and regular service verification.

Participant Satisfaction Survey: asks consumers about program access, participant choice and satisfaction with services, as well as suggestions for improvement.

ii. System Improvement Activities

Responsible Party (check each that applies):	Frequency of Monitoring and Analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Other Specify: Every two years

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The State utilizes several methods to determine the effectiveness of the solution or resolution. The most immediate measure is the ongoing review of care management agencies and participant records which is done

on an on-going basis by the DACS County Liaison/Quality Assurance Specialists, who monitor the response of the sites to corrective actions to ensure that the resolution is addressing the identified problems and that it is effective on an ongoing basis. Data and reports that aggregate information gathered during these monitoring reviews is analyzed and allows for the initial stage of trend identification with follow-up occurring based on the prevalence and scope of the concern. Follow-up could consist of immediate corrective action requests, state-wide trainings being provided or policy and procedure memorandums being developed or updated and distributed to all applicable entities.

A second measure of the process for monitoring and assessing system design changes is the ongoing oversight and audits conducted by the Administering Agency. Level Five of the Quality Management and Improvement System is the Quality Management Unit (QMU) in the Department of Human Services' Division of Medical Assistance and Health Services, which has the ultimate authority for administering oversight and monitoring the GO Waiver program. The Quality Management Unit is responsible for ensuring Administrative Authority Oversight and maintaining a Monitoring Work Plan. As the State Administering Agency, the New Jersey Department of Human Services' Division of Medical Assistance and Health Services has established a Quality Management Unit in its Office of Provider Relations for the purpose of routine and ongoing oversight and monitoring of the Quality Management Strategies implemented by all State Operating Agencies of Medicaid Waiver programs, including those operated by the Division of Aging and Community Services' Office of Long-Term Care Programs. The Quality Management Unit consists of skilled professionals who have a wealth of knowledge regarding diverting and transitioning individuals from nursing facilities and maintaining them in the community. This Unit works collaboratively with other State agencies for information sharing. As the Department of Health and Senior Services Waiver Management Staff conduct ongoing reviews of Discovery information received through Critical Incidence Reporting, quarterly and regional meetings with providers, reports submitted by the Office of Community Choice Options, on-site Quality Assurance visits, financial audits, and surveys conducted, data is analyzed and shared with the Quality Management Unit for use in implementing remediation at the provider and/or regional level and developing strategies for implementation on a State or system-wide level. The Waiver Management Staff may initiate remediation actions including additional provider trainings, restriction of the provider opportunity level for providing services to participants, or termination of a provider agreement. In turn, the Quality Management Unit meets regularly with the Waiver Management Staff to identify concerns and examine remedial actions. As warranted, the Quality Management Unit will schedule interim targeted desk audits to be conducted for care management agencies. All interim targeted desk audits will include random selection of Medicaid Waiver participant records and supporting documents which assess those components targeted for remediation in the Corrective Action Plan. The purpose of the interim targeted desk audit is to track continued compliance to the Corrective Action Plan. Unresolved findings, if noted on interim targeted desk audit, will require a joint on-site visit (i.e., interim targeted on-site audit) by the Department of Human Services' Quality Management Unit and the Department of Health and Senior Services' County Liaison/Quality Assurance Specialists to reach resolution. The Quality Management Unit continuously monitors the outcomes of all Quality Improvement efforts through ongoing Discovery measures to assure the standards of the Waiver program are maintained through all levels of the Quality Management and Improvement Strategy.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Management and Improvement Strategy is an ongoing process whose strategies change over time in response to the changing needs of the Global Options Medicaid Waiver program and the agencies that administer and operate it Statewide. The success of the Quality Management and Improvement Strategy design and operation are reviewed minimally every twenty four months between the Department of Health and Senior Services Division of Aging and Community Services and the Department of Human Services Division of Medical Assistance and Health Services.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

The Global Options for Long-Term Care Medicaid Waiver will not require independent audits of providers as a condition of Waiver participation. At this time, there is no future plan to require independent audits of providers as a condition of Waiver participation.

The Single State Medicaid Agency assures financial accountability for funds expended for home and community-based services, provides for an independent audit of its Waiver programs (except as CMS may otherwise specify for particular Waivers), and maintains and makes available to Health and Human Services, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the Waivers, including reports of any independent audits conducted. The independent accounting firm of KPMG conducts an annual audit in conformance with the Single Audit Act (31 U.S.C. 7501-7507) as amended by the Single Audit Act Amendments of 1996 (P.L. 104-146).

The State employs a number of post-pay procedures to ensure the integrity of payments made for Waiver services including Provider Oversight and Care Manager verification of services. In addition Care Managers need Prior Authorization from the Division of Aging and Community Services' staff to exceed the maximum monthly spending cap of \$2,841. Care Managers also need Prior Authorization from the DACS for all Community Transition Services, Environmental Accessibility Adaptations that cost \$500 or more, and Specialized Medical Equipment and Supplies that cost \$250 or more.

Waiver providers include an individual or entity that meets all qualifications required to provide a specific service and provide authorized services to a participant, pursuant to a Plan of Care. There are three types of providers: a) Participant-Employed Provider b) Traditional Service Provider and c) Non-Traditional Provider. The State has developed a formal process for ensuring that the waiver participant claims are coded and paid in accordance with the waiver reimbursement methodology. Some billing validation entails using the MMIS to validate claims and/or additional pre-pay audit activities conducted by other entities (e.g., verifying that the service billed was included in the participant's service plan) and other billing validation processes are conducted post-payment (e.g., utilization review); including verification that the service billed was actually performed.

Traditional Services are delivered by Medicaid-approved, fee-for-service providers. Services are authorized by approved Care Managers who are responsible to contact providers and participants periodically to confirm service delivery and that services have been provided in the amount and frequency approved in the Plan of Care. For these traditional Waiver services, billed through the State's fiscal agent, and all program costs in general, the Division of Aging and Community Services relies on a number of different expenditures reports. In Fiscal Year 2010, DACS introduced a new County-Based Expenditure and Utilization Report that includes total expenditures, number of unduplicated recipients and service unit count (based on claims for each service category by waiver and State Plan). Based upon these types of reports, the State is able to document that counties continue to provide consumers with a comprehensive array of HCBS that are within the approved budget allocation. As a part of DACS ongoing effort to improve fiscal accountability, this report was revised to include comparison from the current fiscal year to the prior fiscal year.

All GO financial reports are shared and/or placed on shared drives, whereby the Office of Long-Term Care Programs can access the reports, review county/State information, identify changes in utilization, contact county coordinators to gather additional local information that may provide insight into the changes, and if warranted work with county coordinators to take corrective action.

DACS has created a number of fiscal reports that together, provides a comprehensive fiscal analysis of the GO waiver program. MARS reports are one example the types of reports DACS uses to analyze data, identify problems, trend expenditures and utilization, and develop strategies to proactively implement corrective action plans. A MARS Summary of all State and Waiver services for any time period under consideration may include four sections (1) Service categories (Waiver/State Plan services), (2) Paid This Month, (3) Service Expenditures in Current Waiver Year to Date, and (4) Service Expenditures in Prior Waiver Year to Date. Again, this information is shared with DACS staffs who are responsible for reviewing the reports, identifying changes in utilization, contacting county coordinators to gather additional local information that may provide insight into the changes, and if warranted working with county coordinators to take corrective action.

In addition to the monthly MARS Report, DACS also has access to Monthly Projections and Statistical Data reports that are produced by the Department of Health and Senior Services for DACS that historically tracks Actual and Projected Waiver Expenditures and Unduplicated Waiver Recipients. It is this information that enables DACS to monitor performance, identify changes in utilization/ expenditures/costs and ensure expenditures are within the approved the budget.

For Non-Traditional Providers, the Fiscal Intermediary submits invoices on their behalf and pays them for services

rendered. All invoices are for specific participants and the State Fiscal Agent is able, through the process described above, to verify Waiver eligibility prior to payment for services. DHSS maintains a DACS Database System which is designed so the Care Manager can set up services only with providers that have been approved by DACS. The Care Manager enters an Individual Service Agreement onto the DACS Database System to authorize monthly payment amounts to each provider for every service to be delivered to a particular participant. The authorization includes the number of units, frequency, amount and cost. The DACS Database System feeds this authorization information to the fiscal agent. If a provider bills for a service/amount that is not authorized, the fiscal agency does not pay the provider.

The Fiscal Intermediary's contract mandates performance measures for the accuracy and timeliness of the following tasks: submission of bills and invoices, payment to providers, payment of wages to Participant-Employed Providers (PEP), length of processing times, record keeping, updating of manuals and instructions, training in response to requests and changes in regulations, and resolution of claims discrepancies. The Fiscal Intermediary bills the State Fiscal Agent for payment for Participant-Employed Provider and Non-Traditional Provider types based on Individual Service Agreements (ISA) and timesheets for the Participant-Employed Providers and invoices for the non-traditional providers. For non-traditional Waiver Services, the Fiscal Intermediary produces a monthly report to address invoices that do not match authorizations regarding units, rate or frequency (financial irregularities). The claims are in a pending status and no provider can be paid until the issue is resolved.

Participants of the Global Options Waiver may reside in a private home setting, Class B Board Home, or in a licensed Assisted Living (AL) / Adult Family Care (AFC) setting and receive assistance in obtaining the necessary home and community services and supports helping them maintain their independence outside of a nursing facility. Different methods of financial accountability and oversight are established or instituted based on the setting or package of services a GO participant receives. Care Managers for GO participants in an AL facility, for example, are required by policy to verify quarterly that the assisted living services included in the Plan of Care have been delivered as authorized. Verification of services is documented on a form for that purpose. During the DACS on-site survey visit to the care management sites, the file is reviewed for evidence of this form. If it is missing, a deficiency is cited because it is determined that sufficient verification of waiver service delivery is not occurring. Additionally, other reports analyzed by DACS staff identify Assisted Living providers that are not deducting cost share for Waiver participants and for crossover claims. A crossover claim indicates that two institutional providers are billing Medicaid for services on the same day, which is not permissible. These reports are reviewed, analyzed and information is aggregated to detect billing trends. Care Managers are contacted, as applicable, regarding cost share issues and providers regarding crossover claims. As another example, GO participants who opt for home and community-based services, other than those in AL or AFC settings, have a spending cap for services and also may not be authorized to receive services that are duplicative of other services or care rendered. When it was decided to consolidate the previous three DHSS Waivers, it was determined that, based on an analysis of the 372 reports, additional monthly reports from the State's Fiscal Agent' data warehouse, and historical usage of services, it was reasonable to keep the spending cap of \$2,841 a month for all GO participants. This established amount of \$2,841 remains a sufficient and reasonable spending cap for GO participants for the duration of this Waiver renewal. All GO Plans of Care are developed based on a needs-based care allocation. Services are arranged according to the person's assessed need as well as the availability of services and providers. A GO participant, not living in an AL or AFC setting, may receive up to 40 hours, as assessed, of Home-Based Supportive Care each week OR opt to receive the State Plan Personal Care Assistant benefit. These two services are mutually exclusive of one-another meaning a GO participant must choose to receive one or the other, but cannot receive both HBSC and PCA. For these two services, DACS continues to rely on State Fiscal Agent reports that have been custom-made to address cross-over claims and over-billing instances to ensure appropriate oversight of this aspect of the GO program. The latest versions of such reports illustrate spending caps over \$3,000 a month for two consecutive months, or duplicative service crossover claims, by GO participant, by county. Based on analysis of these reports, DACS County Liaison/Quality Assurance staff contact the assigned care management sites to follow-up on the participant's authorized services. In general, staff in the MIS & Data Management Unit (DMU) review the State Fiscal Agent reports and provide the DACS Quality Assurance Unit with the names of individuals or providers for whom overbilling or other issues seem chronic. The problems are discussed with Care Managers as they are discovered. The files of these individuals may be reviewed during the quality assurance surveys. Individual training about the issue is provided directly at that time to the Care Manager. The issue is also addressed globally in future trainings for the Care Managers, Care Management Supervisors and Care Coordinators.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Number and percent of participant claims submitted for participants after the participant's date of death as reviewed via post-payment billing validation processes monitored by DACS through reports run by the State Fiscal Agent and Fiscal Intermediary.

Data Source (Select one):

Mortality reviews

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:
 Number and percent of Community Transition Services that are prior authorized by DACS staff prior to being rendered and reimbursed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Prior Authorization of Individual Service Agreements

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

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

Number and percent of GO participants who receive Assisted Living or Adult Family Care services records with evidence that Cost Share Worksheets that are completed, updated and maintained by Care Managers.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Care Management Supervisors	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from each Care Manager, opened during past 3 years, calculating

		sample size with Conf Intvl of 5; Confidence Level of 95%; Pop Size:# of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of participant records are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

Performance Measure:

Number and percent of Special Requests prior authorized by DACS staff for Environmental Accessibility Adaptations that will cost \$500 or above.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Prior Authorization of Special Requests

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of Special Requests prior authorized by DACS staff for Specialized Medical Equipment and Supplies that will cost \$250 or above.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Prior Authorization of Special Requests

Responsible Party for	Frequency of data	Sampling Approach(check
<input type="text"/>	<input type="text"/>	<input type="text"/>

data collection/generation <i>(check each that applies):</i>	collection/generation <i>(check each that applies):</i>	<i>each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

Number and percent of claims for the waiver service of Home-Based Supportive Care that duplicates claims for the State Plan Personal Care Assistant service.

Data Source (Select one):
Financial records (including expenditures)
 If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every six months

Performance Measure:

Number and percent of participant records with evidence that Care Managers monitor and verify the delivery of waiver services as authorized in the Plan of Care by

reconciling Service Cost Records quarterly.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Care Management Supervisor	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from each Care Manager, opened during past 3 years, calculating sample size with Conf Intvl of 5; Confidence Level of 95%; Pop Size: # of Enrolled participants; Response Distribution of 50%
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: A random sample of participant records are audited by each CM Supervisor at least annually.
	<input checked="" type="checkbox"/> Other Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

Performance Measure:
Number and percent of Management and Administrative Reporting System (MARS) Summary Reports analyzed monthly by DACS which outlines all state and waiver services by month to track utilization by county.

Data Source (Select one):
Financial records (including expenditures)
 If 'Other' is selected, specify:
MARS Summary Report

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

Data Aggregation and Analysis:

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Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

Number and percent of analyzed 'Projections and Statistical Data Reports' that track actual and projected expenditures and unduplicated participants.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

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

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

Number and percent of participant records with evidence that each participant's Plan of Care is based on the individual's completed comprehensive evaluation and needs based care allocation tools.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Records from each Care Manager, opened during past 3years, calculating

		sample size with Conf Intvl of 5; Confidence Level of 95%; Pop Size:# of Enrolled participants; Response Distribution of 50%
<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other	Specify: A random sample of Plans of Care are audited by each CM Supervisor at least annually.
<input checked="" type="checkbox"/> Other		Specify: Every two years

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every two years

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

The State employs a number of post-pay procedures to ensure the integrity of payments made for Waiver services including not only Provider Oversight, Care Manager verification of services, and State Fiscal Agent reporting, but also Prior Authorization of select services prior to their delivery. When the waivers were consolidated, it was established that Care Managers would need Prior Authorization from DACS professional staff to exceed the maximum monthly spending cap of \$2,841. Care Managers also need Prior Authorization from the Division of Aging and Community Services' staff for all Community Transition Services, Environmental Accessibility Adaptations (EAA) that cost \$500 or more, and Specialized Medical Equipment and Supplies (SME) that cost \$250 or more.

Additionally, authorized services are identified as an assessed need and documented in each participant's Plan of Care. Each participant's Plan of Care is based on the individual's completed comprehensive evaluation and

needs based care allocation tools. If services to meet a participant’s care needs are assessed to exceed \$2,841 a month, the Care Manager will review the exception with his or her Supervisor. When the Supervisor confirms the need, the request will be submitted to the designated DACS professional staff.

Identifying and Addressing Financial Irregularities

Historically, as a way of practicing financial accountability, DACS has solicited and refined spending reports made available from the programs fiscal intermediaries. SenIORs, a group of programmers within the State’s Fiscal Agent is under contract to DHSS for special projects to periodically run reports to provide information regarding any participants whose monthly spending exceeded. For traditional Waiver Services, DACS continues to rely on the State Fiscal Agent reports that have been custom-made to address over-billing.

The latest version of this report is now generated quarterly and illustrates spending caps over \$3,000 a month for two consecutive months, by GO participant, by county. DACS Quality Assurance Unit staff contact the assigned care management sites to follow-up on the participant’s authorized services and in all cases, of questionable billing practices, continual investigation is pursued until a clear resolution occurs and any billing is resubmitted to the State Fiscal Agent as necessary.

Waiver services while in an Adult Family Care or Assisted Living setting

There are three areas for potential financial issues in Assisted Living / Adult Family Care settings that DACS monitors: A) that cost share is deducted when applicable, B) that Assisted Living providers do not bill the per diem cost when the Waiver participant is out of the building temporarily in a hospital or nursing facility, and C) that Assisted Living participants do not receive duplication of services. To that end DACS has taken the

The DACS Quality Assurance Unit staff is in constant communication with other State staff from Medicaid, other DACS Offices/Units, and HFEL to address any financial irregularities on an as needed basis.

Prior to an on-site survey of a care management agency, the DACS County Liaison in charge of the survey knows the Assisted Living participants whose files will be audited. He or she checks the State Fiscal Agent for the provider claims to determine whether cost share has been deducted. (Not all participants will have a cost share, but for those that do, it should be deducted from the claim before it is sent to the State Fiscal Agent). The claims screen is printed and taken to the survey site. The County Liaison reviews the file to determine whether there is a cost share worksheet and, if there is, if the cost share amount equals the cost share indicated in the claims screen. If there are discrepancies, they are discussed with the Care Manager at the time of the monitoring review.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
In general, the Quality Assurance Unit and staff in the MIS & Data Management Unit (DMU) review the State Fiscal Agent reports and problems are discussed with Care Managers as they are discovered. The files of these individuals may be reviewed during the quality assurance surveys. Individual training about the issue is provided directly at that time to the Care Manager. The issue is also addressed globally in future trainings for the Care Managers, Care Management Supervisors and Care Coordinators.

As needed, DACS staff includes training on the topic of Cost Share Worksheets at the Care Coordinator/Care Manager quarterly meetings and the six Regional Care Manager meetings. DACS staff also conducts at least two Statewide Assisted Living provider trainings annually and cost share computation and requirements are always listed as agenda items. A representative from the State Fiscal Agent presents on appropriate billing practices as well. In addition to audits and trainings, report analysis has been another method used in which to minimize financial irregularities.

ii. Remediation Data Aggregation

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Continuously and Ongoing	
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

c. Timelines

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

No

Yes

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

Assisted Living/Nursing Facility Crossover Claims

Presently, Assisted Living (AL) rates are predicated upon the requirement that a facility only bills Medicaid the per diem for days that the waiver participant is actually in the AL facility and receiving AL services. If a GO participant is absent from the AL for medical reasons, e.g. in a hospital, nursing home, or rehabilitation facility, the AL facility is not permitted to include the days absent as billable units in its monthly claims to the State Fiscal Agent.

Although the State has a formal process it has used in the past to assure the integrity of payments that have been made for Assisted Living waiver services, DACS has discovered its methods to this end are very labor intensive and improved systemic follow-up actions are being pursued. Historically, the DACS Quality Assurance Unit and Supervisor of the Data Management Unit requested that the SURS staff provide a quarterly report of crossover claims that show if/when an Assisted Living Provider submits Assisted Living claims for days when Medicaid is paying for the individual in another institutional setting. The DACS Waiver Administrator would follow-up through a series of telephone calls to applicable provider facilities and the State Fiscal Agent claims look ups to investigate each suspected billing irregularities. It was discovered that for the most part, the reports have shown appropriate billing and many of the hospital claims were for same day treatment so the AL participant was still considered part of the official census of the AL facility and the AL facility billed appropriately. In few instances where there could have been crossover claims for one-two days, the facility was contacted to remind the business office/Administrator that the facility does not bill Medicaid for the day of discharge from the facility, but does bill for the day of readmission. To date, DACS has not determined any trends where a facility has multiple instances of submitting bills on a day when the participant is not in the facility.

GOAL: Staffing shortages have made the previous follow-up activities accomplished to-date difficult to undertake. To refine this process, one Information Systems Analyst from the DACS MIS & Data Management Unit has been assigned to collect and analyze this Crossover Claims report on a quarterly basis to identify providers/corporations that bill for participants who have been transferred to another healthcare setting. The Analyst, with assistance from Quality Assurance Unit staff, will investigate errors in billing and follow-up with a letter to the provider facilities identifying billing irregularities and directing them to reconcile the discrepancy. A more systematic approach to this type of investigation is being developed to be implemented in calendar year 2011.

Assisted Living Cost Share

Past Cost Share reports for Assisted Living Cost Share were intended to identify Assisted Living providers who are not deducting the recipient's cost share from their Assisted Living Residence / Comprehensive Personal Care Home claims. The recipient's cost share is recorded either in their TPL payment amount field or subtracted from the total claim charge amount.

The past method of investigation proved too unmanageable and inefficient to address on case-by-case basis as it has been. DACS requested an official investigation into Assisted Living and Cost Share Deduction be conducted by the State's Bureau of Program Integrity (Medicaid Fraud Unit). Since that request, the Chief of Investigations

has requested copies of all applicable Cost Share Worksheets from care management sites statewide in order to begin the investigation and pursue subsequent follow-up with facilities which have questionable billing practices in order to facilitate billing claims reconciliation. In May 2011, the entire case was screened with the Office of the State Comptroller's chief of investigations and the decision was made to send the referral to their audit department for completion. In addition to working with the Office of the State Comptroller, the Division of Aging and Community Services has consulted with the Division of Medical Assistance and Health Services regarding the Request for Proposal (RFP) for the next State Fiscal Agent. DACS proposed incorporating into the RFP that the State Fiscal Agent include in the Medicaid management information system the ability to accurately reflect cost sharing responsibilities for applicable GO participants.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

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

Effective July 1, 1996, the Department of Health and Senior Services, as specified in the Interagency Agreement with the Department of Human Services, became responsible to establish rate methodologies and rates of payment for providers of Nursing Facilities, Special Care Nursing Facilities, Home Care Expansion Program (no longer in existence as last enrollee was transferred to a Waiver Program), Medical Day Care, Social Day Care, Assisted Living Residences, Assisted Living Programs, Comprehensive Personal Care Homes, Alternate Family Care (former name of Adult Family Care), and Respite Care Services. (Please note that Enhanced Community Options [ECO] did not exist in 1996, but is incorporated by practice in the above list.) For programs and services where the rate methodology and rates of payment for providers of services directly affect Waiver services, specifically Home Health Agencies, Homemakers (were utilized instead of Personal Care Assistant in Department of Health and Senior Services Waivers since 1983), and Care Management, rate methodology and rates of payment are developed by the Department of Human Services in consultation with the Department of Health and Senior Services.

The reimbursement rates are determined by regulation, which requires publication of proposed regulations including changes to reimbursement rates before the regulation can be adopted. When changes in reimbursement rates are proposed, public comment is invited. When final regulations are adopted, including changes in rate reimbursement, the Division of Medical Assistance and Health Services must respond to each comment submitted. Responses are published as part of the regulation adoption.

The service of Assisted Living was first approved within the Assisted Living Waiver which was initiated in 1996. According to Staff from the Budget Office in the Division of Management and Administration for the Department of Health and Senior Services, the average Medicaid per diem cost in a Nursing Facility was \$89.66 in 1996. This amount was used as the starting point from which to develop a per diem reimbursement rate for services in the Assisted Living Residence (ALR), Comprehensive Personal Care Home (CPCH), Assisted Living Program (ALP), and Adult Family Care (AFC). The initial rates were Assisted Living Residence/\$60, Comprehensive Personal Care Homes/\$50, and Assisted Living Program/Adult Family Care/\$40. The difference in the per diem reimbursement rates were based on the higher costs for capital expenses for construction of new buildings (ALR) as opposed to upgrading an existing Residential Health Care Facility or Class C Boarding Home (CPCH) or using existing housing stock in the AFC caregiver's home or ALP, which was provided in publicly subsidized housing. The rates were determined equitable, compared to those of a nursing facility, because Staffing requirements were less than those for a nursing facility, health care services could be arranged as opposed to being provided by the Assisted Living Staff, and the administration of medications could be delegated by the Assisted Living Facility's Registered Nurse; in a nursing facility only a licensed professional could administer medications. The rates remained the same until January 2007, when the Legislature approved a \$10 a day increase across the board.

In 1999, the Assisted Living Waiver was renewed and amended. It became known as the Enhanced Community Options Waiver and added the Caregiver Assistance Program as well as nine additional in-home services. Rates for Care Management, Respite, and Social Adult Day Care remained the same as they were in the then called Community Care Program for the Elderly and Disabled Medicaid Waiver. Environmental Accessibility Adaptations and Transportation rates were consistent with the Assisted Living Waiver at the time.

In order to compute the units, rates, and rate of participant use for the additional services for the 1999 Enhanced Community Options renewal, 26 sources of information were used as resources to determine the universe of Waiver clients based on age, estimate of those who were income eligible for the Waiver, limitations in self-care or mobility, and projected utilization rates and service costs. The original information as projected as baseline data for the 1999 renewal is as follows:

Attendant Care – Based on the Home-Based Supportive Care rate and increased by 5% as premium for special needs care = $15 \times 1.05 = \$15.75$, rounded to \$16.

Special Medical Equipment and Supplies – Rates were based on codes and reimbursement list with 5% increase = $50 \times 1.05 = 52.5$ rounded up to \$53. At the time of the 2004 Enhanced Community Options renewal, rates were determined on usual and customary charge up to \$250. Specialized medical equipment and supplies in excess of that cost requires Prior Authorization from the Office of Global Options for Long-Term Care & Quality Management Staff.

Home Delivered Meals – based on reports of Home Delivered Meals increased 5% for 1997 and 5% for 1998 = 5.08 and bumped up to \$6.

Caregiver Recipient training – based on findings of Certified Homemaker Home Health Aide course cost (\$70) increased 5% = \$73.5 bumped for 1998 up to \$75.

Personal Emergency Response Systems – based on reported costs. Some include purchased units, plus installation, plus monthly fee. Others are installation plus monthly fee/rental combined. Usual and customary charge for Personal Emergency Response System installation is up to \$75; Monthly monitoring fee is up to \$45; average of both is \$50.

Home-Based Supportive Care (HBSC) – based on mean hourly wage for Home Health Agency services (\$8.30) rounded to \$9, increased 5% to \$9.45, rounded to \$10, increased 10% consistent with homemaker = $\$10 + \$1 = \$11$, plus 25% employer processing = \$13.75 rounded to \$14 and bumped to \$15. Reimbursement for the Participant-Employed Provider is Minimum wage to \$9/hr.; Home-Based Supportive Care Agency is the usual and customary charge to \$15.40 per hour.

Chore Service – Mean hourly wage of janitors and cleaners (\$9.50), rounded to \$10, plus 25% employer processing costs = \$12.50, rounded to \$13 and bumped to \$14. Reimbursement rate is usual and customary charge up to \$50.

Initial Care Management – one fee consistent with Traumatic Brain Injury Waiver. This was necessary because of additional detail in front-end activities of Care Manager, which are necessary to ensure proper services and quality of care.

Nursing facility per diem rates are adjusted annually based on a facility's cost reports for the previous year. Nursing facilities may provide respite for Global Options for Long-Term Care Waiver participants.

Adult Day Health (ADH) providers are one of three types: nursing facility (NF) based, freestanding and hospital affiliated.

- Historically, in a nursing facility-based Adult Day Health facility, the per diem rate was 45% of the nursing facility rate before add-ons. This rate changed every time the nursing facility rate changed. These rates could change a few times a year, largely because of appeals from the nursing facilities. In freestanding centers, the Adult Day Health rate was based on an average of the rates paid to nursing facility medical day care providers. The rates changed once a year, effective July 1 of each year. The new rates for the nursing facility medical day care providers were added together and divided by the number of nursing facility providers. This gave the freestanding rate. Finally, in Hospital affiliated Adult Day Health centers, the rate changed once a year, effective July 1 of each year. In the past, the highest rate of the nursing facility-based Adult Day Health provider was the hospital rate.

- Effective July 1, 2009, the State established one flat fee-for-service rate for Adult Day Health Services, in all approved medical day setting types, of \$78.50.

Certified Home Health agency rates are cost based and can change yearly. There is a reconciliation of expenditures completed annually by a contracted agency through the Division of Medical Assistance and Health Services.

The maximum Waiver rate for Social Adult Day Care (SADC) is set at \$31.12 per day and has remained so since 1991.

The Care Management rates have been fixed at \$200 a month for the initial visit to open the case, which includes visiting and assessing the client and developing the Plan of Care and \$95 a month for the regularly scheduled contacts

and quarterly visits. These rates were established effective January 1, 2001, and were predicated upon the rates and responsibilities of Waiver Care Managers in other States.

Transitional Care Management Costs, for the first month of GO enrollment when the Care Manager has participated in an Interdisciplinary Team meeting for an institutionalized Waiver applicant, are reimbursed at the standard initial Care Management reimbursement rate up to a total of \$200. This is a one time only unit of service. Transitional Care Management Costs, for a period up to three months during a GO participant's subsequent nursing facility stay, may be reimbursed at the standard monthly Care Management reimbursement rate (\$95) up to a total of \$285 only if the GO participant returns back to the community.

Community Transition Services are based on the individual's assessed needs in order to relocate. All Community Transition services require that written estimates of the cost of purchases/services necessary to relocate are submitted to the Division of Aging and Community Services' Central Office Staff for Prior Authorization.

Care Managers discuss service rates with the participant and/or his representative/legal representative when developing the Transition Plan or Plan of Care as a matter of course in determining which services are available to best meet the participant's needs as identified in the comprehensive evaluation. Information is made available to GO waiver participants about payment rates so that they are aware of the costs of waiver services. This is done on several occasions: if an Interdisciplinary Team meeting is conducted upon someone's transition onto GO from a Nursing Facility, when a Plan of Care is developed or updated by the participant and his or her Care Manager, when the Service Cost Record for an individual is completed or updated by the Care Manager upon enrollment onto the program, and if the GO participant exercises Employer Authority when utilizing the Participant Employed Provider option in GO to hire their own employee to render select waiver services.

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

Waiver services are not billed to the State. All billings from providers of traditional services flow directly from providers to the State's claims payment system. The service provider submits claims for services, either electronically or as hard copy, directly to the State's Fiscal Agent. Each claim item is assigned a unique internal control number (ICN) for claim identification purposes. Provider reimbursement for services appears on the provider's weekly remittance advice Statement, which indicates, by internal control number, which services were reimbursed.

For non-traditional providers of waiver services, the flow of billings is as follows:

- Providers submit invoices to the Fiscal Intermediary within six months of service provision.
- Invoices must include the name of the participant served, Medicaid service code, units of service, rate of service, provider Federal Tax ID, and Provider Address.
- Individual Service Agreement (ISA) data, created by the Care Manager and entered on the DACS Database (formerly called the Home and Community-Based Services- HCBS website), is transferred from the State's DACS Database system to the Fiscal Intermediary on a daily basis.
- The Fiscal Intermediary compares provider claims to Individual Service Agreement data within 30 days of invoice receipt.
- The Fiscal Intermediary pays providers by direct deposit or paper check within 30 days of invoice receipt/timesheets.
- Each Direct Deposit or paper check includes a remittance advice, showing all claims paid, pending or denied.
- The Fiscal Intermediary submits claims to the State's Fiscal Agent for reimbursement.

The State is informed of the claims submitted and processed through direct access to the State's Fiscal Agent claims system. Relevant staff in the Division of Aging and Community Services' Data Management and Office of Long-Term Care Programs has completed the five-day training program offered by the State's Fiscal Agent to learn the intricacies of navigating its client and provider systems.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

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

No. State or local government agencies do not certify expenditures for waiver services.

Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

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

Financial oversight in the State of New Jersey exists in several capacities including through the provision of its financial monitoring processes, review of participant claims and financial irregularities, the conduct of regular meetings and on-going discussions with State staff and providers, and the maintenance of financial records as necessary.

Ultimately, the New Jersey Medicaid Management Information System (NJMMIS) Recipient Subsystem provides and maintains a single source of eligibility information for Global Options Waiver recipients. The Recipient Subsystem has been developed to accomplish the following objectives:

- Maintain identification of all applicants eligible for GO
- Provide timely updating of the Recipient History Master File to include new recipients and all changes to existing recipient records
- Maintain positive control over all data pertaining to GO Waiver Eligibility
- Build and maintain a computer file of GO recipient data to be used for forms processing, administrative reporting surveillance and utilization review
- Distribute GO eligibility data to the other processing agencies

The Recipient Subsystem accepts data from the Division of Medical Assistance and Health Services (DMAHS) to maintain demographic, eligibility, special program and lock-in data on the Recipient History Master File (RHMF). The Recipient History Master File maintains a history of recipient eligibility periods as derived from the State's update files. The State sources are daily and monthly Medicaid Eligibility Files maintained by the State Office of Information Technology. Global Options for Long-Term Care participants have the Special Program Code (SPC) of 32.

All Provider claims from traditional Medicaid enrolled providers for Waiver services are processed through the Claims Processing Subsystem and are subject to complete and comprehensive editing. The edits are designed to determine coverage in accordance with State and Federal policies and procedures to prevent erroneous payments.

The Claims Processing Subsystem supports input processing and edit/price processing on a daily basis, history audit processing twice a week, and payment processing weekly. The daily cycle enforces non-history related edit requirements and establishes tentative payment amounts on all claim types. The history cycle enforces history-related edit requirements, including duplicate claim detection, service limitation edits, Prior Authorization edits, service conflicts, cutback pricing and third-party liability related edits. The history cycle establishes final payment amounts for approved claims.

NJ Medicaid Management Information System (NJMMIS) is comprised of edits that are hard coded in order to approve or deny payment to providers. Providers may only bill for the procedure codes within their specialty. When a provider applies to become a Medicaid provider they are put in a category according to their specialty. This specialty code only allows providers to bill for specific service procedures. Within each procedure code there are limitations to the number of units that can be billed and the amount paid per unit. Therefore, providers are restricted from billing over the Medicaid rate or too many hours/units.

The DACS MIS & Data Management Unit (DMU) developed and produces numerous monthly and/or quarterly reports on data collected from the NJMMIS Claims Payment System. The data is collected in a shared data warehouse by Fiscal Agent staff and is available via the web.

The billing validation process is largely post-pay through utilization reports. MIS & Data Management staff develops reports that compile recipient and expenditure data by Waiver program, county and service. These reports are produced by payment date and distributed throughout the Division, Department and OMB.

Section XIII of the Interagency Agreement between Department of Health and Senior Services and Department of Human Services details the specific responsibilities of each Department regarding reports, forms, and procedures that largely deal with fiscal matters. Department of Human Services provides Department of Health and Senior Services with a number of specific fiscal reports that are used in determining compliance with the financial parameters of service delivery. The reports are reviewed by Department of Health and Senior Services Staff, including Supervisory staff from the DACS Quality Management Staff, County Liaisons/Quality Assurance Specialists, and Data Management Staff to assure that approved services are delivered to eligible participants in limits defined by the Waiver and cost caps. Follow up to Care Managers and/or providers are made as necessary for explanation/correction. Copies of the Management and Administrative Reports (MARS) from Medicaid, which contain payment information on a date of payment schedule are also downloaded and reviewed by a fiscal analyst in the Office of Data Management on a monthly basis to detect over billing. As stated above, the Office MIS & of Data Management additionally creates monthly reports, based on paid claims data from the State's fiscal Agent, that provide information on State Plan and Waiver service utilization/costs and county spending trends. The reports allow the DACS Quality Management Staff to analyze the findings, detect trends, and ensure corrective actions have been taken to resolve problems.

Additional reports are analyzed for Assisted Living participants to assure that a) cost share is deducted when applicable; b) Assisted Living Facility and Program/Adult Family Care providers do not bill the per diem cost when the participant is out of the building temporarily in a hospital or nursing facility and that those individuals that request the Assisted Living Facility Service do not attend Adult Day Health Services because that would constitute a duplication of services.

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such

payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The contracted, approved Fiscal Intermediary pays non-traditional providers of Waiver services, i.e., Attendant Care, Chore Service, Caregiver Recipient Training, Environmental Accessibility Adaptations, Home-Delivered Meals, Home-Based Supportive Care, Respite, Social Adult Day Care, Transportation, Personal Emergency Response System, Specialized Medical Equipment & Supplies, and Community Transition Services. The Fiscal Intermediary electronically submits bills to Medicaid Management Information System for reimbursement of payments the Fiscal Intermediary has made to home and community-based services providers on behalf of participants participating under Waiver Programs. The Fiscal Intermediary configures its claim submittals according to current Medicaid Management Information System electronic media claims (EMC) specifications and fulfill all the requirements of a Medicaid provider. (The Fiscal Intermediary is enrolled as a Medicaid provider.) The Medicaid Agency has access to all claims submitted by the Fiscal Intermediary through Medicaid Management Information System to oversee the operations of the limited Fiscal Intermediary contracted agent.

The Fiscal Intermediary sends a form letter to all new providers that provides contact information for the

provider to call with billing questions, an explanation of the billing process that includes an electronic invoice option utilizing an Excel worksheet that is deliverable to the Fiscal Intermediary via a secure FTP site, an invoice form that can be submitted manually, information regarding vouchers, and a form to collect provider company information.

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

No. The State does not make supplemental or enhanced payments for waiver services.

Yes. The State makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

- d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

County Welfare Agencies and Area Agencies on Aging receive payment for Waiver care management services.

Appendix I: Financial Accountability

Amount of Payment (6 of 7)

e. Amount of Payment to State or Local Government Providers.

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

The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Empty text box with a scroll arrow on the right side.

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Empty text box with a scroll arrow on the right side.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

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

No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

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

The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The State contracts with a Managed Care Organization(s) (MCO) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:***

- Appropriation of State Tax Revenues to the State Medicaid agency
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appropriation of State tax revenues from the State General Fund as well as appropriation of casino tax revenues from the Casino Revenue Fund provide the State level source of the non-federal share of computable Waiver costs. The benefit payments for the Department of Health and Senior Services and the Department of Human Services providers are processed through the State Fiscal Agent with checks and electronic fund transfers made from a single bank account in accordance with the annual State budget. The draw down of funds for both the Department of Health and Senior Services and the Department of Human Services payments is based on the clearance of checks and wires as monitored by the Department of Treasury, Office of Management and Budget.

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

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

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

- Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:



Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

- c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

- Health care-related taxes or fees**
 Provider-related donations
 Federal funds

For each source of funds indicated above, describe the source of the funds in detail:



Appendix I: Financial Accountability

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

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

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

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

The Waiver Service of Respite may be provided in a Nursing Facility or an Assisted Living Facility or Adult Family Care Home. Federal financial participation is claimed in expenditures for the cost of room and board only when provided as part of respite care in a facility approved by the State that is not a private residence.

The Respite rate for the nursing facility is 100 percent of its per diem rate. The per diem rate is all-inclusive and covers room and board and all services that the participant needs. Room and board costs are not isolated or defined and are not factored out as a separate cost. This methodology has been in place since at least 1996.

The Respite rate for Assisted Living Facilities and Adult Family Care is a flat rate of \$100 per diem for the supervision, personal care and health services that the participant needs. There is no additional charge for room and board. The Respite rate was determined by the Division of Aging and Community Services' Central Office in April 2002 and has remained the same.

The non-Respite rates for the Assisted Living and Adult Family Care are as follows:

- Assisted Living Residence (Assisted Living Facility) is \$70 per diem for services provided to the Waiver participant;
- Comprehensive Personal Care Home (Assisted Living Facility) is \$60 per diem for services provided to the Waiver

participant; and

- Adult Family Care is \$ 50 per diem for services provided to the Waiver participant in Adult Family Care. The non-Respite rates do not include Room and Board. They are the per diem reimbursement rates for services provided to Waiver participants in Assisted Living Residences, Comprehensive Personal Care Homes, or Adult Family Care. The Waiver participant pays Room and Board separately to the provider, in all three venues, in an amount defined annually by the Department.

The Waiver participant who chooses the Assisted Living Program in Subsidized Housing pays rent to his or her landlord according to the terms of the individual's lease.

Appendix I: Financial Accountability

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

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

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

No. The State does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.

- i. Co-Pay Arrangement.**

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

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible
- Coinsurance

- Co-Payment
 Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

- a. Co-Payment Requirements.
- ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

- a. Co-Payment Requirements.
- iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

- a. Co-Payment Requirements.
- iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

- b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

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

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	13256.30	8693.00	21949.30	50201.00	3661.00	53862.00	31912.70
2	13654.64	8954.00	22608.64	51707.00	3770.00	55477.00	32868.36
3	14064.88	9222.00	23286.88	53258.00	3884.00	57142.00	33855.12
4	14489.40	9499.00	23988.40	54856.00	4000.00	58856.00	34867.60
5	14919.89	9784.00	24703.89	56502.00	4120.00	60622.00	35918.11

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

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

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	13438	13438
Year 2	14110	14110
Year 3	14816	14816
Year 4	15557	15557
Year 5	16335	16335

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

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

The Average Length of Stay (ALOS) used baseline data from CMS-372 GO Waiver SenIORS lag report(from 1/1/2010 - 12/31/2010). The days as reported are 334 or 11 months ALOS.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

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

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

A. Basis for the unduplicated number of participants (Users):

- Based on US Census Bureau the rate of population change for the State of New Jersey, is 5%.
- Baseline Data was taken from CMS-372 GO Waiver SenIORS lag report (1/1/10 - 12/31/10).
- The number of individuals receiving each service was increased by 5% a year, as determined by the U.S. Census Bureau to adjust for the growth during the two years between 2010 and 2012.
- In years 1 through 5 of the renewal, the number of users was increased by the estimate population change for State of New Jersey as determined by the U.S Census Bureau. The rate for New Jersey is 4.5 percent, which the Division of Aging and Community Services (DACS) rounded up to 5 percent.

B. Basis for the derivation of unit costs for Waiver Services:

- The average cost for each Waiver service was increased by three percent each year starting in year 1 through year 5 of the renewal; we used the actual current average cost per unit rate for each service as the baseline. This number was increased by 3% twice to reflect the two-year interval between the CMS-372 GO Waiver SenIORS lag report (1/1/10- 12/31/10) and the amendment year.

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

The baseline for Factor D' was calculated by taking the average per capita cost of all state plan services as provided in the CMS-372 GO Waiver SenIORS lag report (1/1/10- 12/31/10) and multiplying the Factor D' by 3% twice to reflect the two year interval between the CMS-372 GO Waiver SenIORS lag report (1/1/10- 12/31/10) and the amendment year. The cost was trended forward at 3% a year (CPI rate of inflation) in years 1 through 5 of the renewal.

As of April 2006, Medicare Part D was implemented for those prescription medications that may have been previously covered under Medicaid. The Medicare Part D prescription medications were no longer captured in the CMS 372 reports since the medications were not billed to Medicaid. The Medicaid claim system, as far as pharmacy claims are concerned, processes claims the same for all Medicaid recipients. Any reports used (lag and others) would exclude Medicare Part D costs too because they are not paid to the pharmacy through the Medicaid claim payment system; estimates were trended forward for renewal waiver years to show D' without pharmacy costs.

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

The Division of Aging and Community Services used actual data from the State Fiscal Agent(Molina) lag Report S6559R20 (01/01/09- 12/31/09), to establish a baseline for Factor G, the average per capita Long-Term Care expenditures. The baseline for Factor G was multiply by 3% (CPI rate of inflation) thrice to reflect the three-year interval between the Molina lag report S6559R20 (01/01/09- 12/31/09) and the amendment year. The actual number was then trended forward using the Consumer Price Index three percent for Factor G to arrive at Waiver Year 1 through 5 projections.

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

The Division of Aging and Community Services used actual data from the State Fiscal Agent (Molina) lag Report S6559R20 (01/01/09 through 12/31/09) to establish a baseline for Factor G', the average per capital cost for acute care services for individuals in a nursing facility. The baseline for Factor G' was multiply by 3% (CPI rate of inflation) thrice to reflect the three-year interval between the Molina lag report S6559R20 (01/01/09- 12/31/09) and the amendment year. The actual number was then trended forward using the Consumer Price Index three percent for Factor G' to arrive at Waiver Year 1 through 5 projections.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.

Waiver Services
Care Management
Respite
Adult Family Care
Assisted Living (ALR or CPCH)
Assisted Living Program (ALP) in Subsidized Housing
Attendant Care
Caregiver Participant Training
Chore Services
Community Transition Services
Environmental Accessibility Adaptations (EAA)
Home-Based Supportive Care
Home-Delivered Meals
Personal Emergency Response System (PERS)
Social Adult Day Care
Specialized Medical Equipment and Supplies
Transitional Care Management
Transportation

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Management Total:						7558555.10
Initial CM	Initial Month	1730	1.00	199.87	345775.10	

Monthly CM	Monthly	8436	9.00	95.00	7212780.00	
Respite Total:						761910.24
Respite	Day	273	16.00	174.43	761910.24	
Adult Family Care Total:						479678.50
Adult Family Care	Per diem	35	310.00	44.21	479678.50	
Assisted Living (ALR or CPCH) Total:						65591110.96
ALR	Per diem	3462	263.00	59.32	54011215.92	
CPCH	Per diem	896	251.00	51.49	11579895.04	
Assisted Living Program (ALP) in Subsidized Housing Total:						5785600.00
Assisted Living Program (ALP) in Subsidized Housing	Per diem	452	256.00	50.00	5785600.00	
Attendant Care Total:						17647.02
Attendant Care	Per hour	2	657.00	13.43	17647.02	
Caregiver Participant Training Total:						4500.00
Caregiver Participant Training	Per need	10	6.00	75.00	4500.00	
Chore Services Total:						71809.40
Chore Services	Per job	65	71.00	15.56	71809.40	
Community Transition Services Total:						16456.44
Community Transition Services	Per transition	22	1.00	748.02	16456.44	
Environmental Accessibility Adaptations (EAA) Total:						578317.44
Environmental Accessibility Adaptations (EAA)	Per job	191	2.00	1513.92	578317.44	
Home-Based Supportive Care Total:						92647828.08
Home-Based Supportive Care	Per hour	7803	772.00	15.38	92647828.08	
Home-Delivered Meals Total:						1827278.88
Home-Delivered Meals	Per meal	1324	186.00	7.42	1827278.88	
Personal Emergency Response System (PERS) Total:						978028.80
Personal Emergency Response System (PERS)	Monthly	3830	8.00	31.92	978028.80	
Social Adult Day Care Total:						238153.50
Social Adult Day Care	Day	130	59.00	31.05	238153.50	
Specialized Medical Equipment and Supplies Total:						1527424.80
Specialized Medical Equipment and Supplies	Per month	2068	12.00	61.55	1527424.80	

Transitional Care Management Total:						40185.04
Initial	Per transition	190	1.00	200.00	38000.00	
Monthly	Per transition	22	1.00	99.32	2185.04	
Transportation Total:						14160.30
Transportation	Trip	14	55.00	18.39	14160.30	
GRAND TOTAL:						178138644.50
Total Estimated Unduplicated Participants:						13438
Factor D (Divide total by number of participants):						13256.30
Average Length of Stay on the Waiver:						11

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit ^{Co}	Component Cost	Total Cost
Care Management Total:						8174657.62
Initial CM	Initial Month	1816	1.00	205.87	373859.92	
Monthly CM	Monthly	8858	9.00	97.85	7800797.70	
Respite Total:						824998.72
Respite	Day	287	16.00	179.66	824998.72	
Adult Family Care Total:						522343.80
Adult Family Care	Per diem	37	310.00	45.54	522343.80	
Assisted Living (ALR or CPCH) Total:						70937114.23
ALR	Per diem	3635	263.00	61.10	58411905.50	
CPCH	Per diem	941	251.00	53.03	12525208.73	
Assisted Living Program (ALP) in Subsidized Housing Total:						6262400.00
Assisted Living Program (ALP) in Subsidized Housing	Per diem	475	256.00	51.50	6262400.00	
Attendant Care Total:						18172.62
Attendant Care	Per hour	2	657.00	13.83	18172.62	

Caregiver Participant Training Total:						5098.50
Caregiver Participant Training	Per need	11	6.00	77.25	5098.50	
Chore Services Total:						77392.84
Chore Services	Per job	68	71.00	16.03	77392.84	
Community Transition Services Total:						17720.58
Community Transition Services	Per transition	23	1.00	770.46	17720.58	
Environmental Accessibility Adaptations (EAA) Total:						623736.00
Environmental Accessibility Adaptations (EAA)	Per job	200	2.00	1559.34	623736.00	
Home-Based Supportive Care Total:						100200165.12
Home-Based Supportive Care	Per hour	8194	772.00	15.84	100200165.12	
Home-Delivered Meals Total:						1975245.60
Home-Delivered Meals	Per meal	1390	186.00	7.64	1975245.60	
Personal Emergency Response System (PERS) Total:						1057946.88
Personal Emergency Response System (PERS)	Monthly	4022	8.00	32.88	1057946.88	
Social Adult Day Care Total:						258494.34
Social Adult Day Care	Day	137	59.00	31.98	258494.34	
Specialized Medical Equipment and Supplies Total:						1652457.60
Specialized Medical Equipment and Supplies	Per month	2172	12.00	63.40	1652457.60	
Transitional Care Management Total:						43346.90
Initial	Per transition	199	1.00	206.00	40994.00	
Monthly	Per transition	23	1.00	102.30	2352.90	
Transportation Total:						15625.50
Transportation	Trip	15	55.00	18.94	15625.50	
GRAND TOTAL:						192666916.85
Total Estimated Unduplicated Participants:						14110
Factor D (Divide total by number of participants):						13654.64
Average Length of Stay on the Waiver:						11

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/Unit ^{Co}	Component Cost	Total Cost
Care Management Total:						8841390.39
Initial CM	Initial Month	1907	1.00	212.04	404360.28	
Monthly CM	Monthly	9301	9.00	100.79	8437030.11	
Respite Total:						891200.80
Respite	Day	301	16.00	185.05	891200.80	
Adult Family Care Total:						567021.00
Adult Family Care	Per diem	39	310.00	46.90	567021.00	
Assisted Living (ALR or CPCH) Total:						76721186.47
ALR	Per diem	3817	263.00	62.93	63173602.03	
CPCH	Per diem	988	251.00	54.63	13547584.44	
Assisted Living Program (ALP) in Subsidized Housing Total:						6763238.40
Assisted Living Program (ALP) in Subsidized Housing	Per diem	498	256.00	53.05	6763238.40	
Attendant Care Total:						18724.50
Attendant Care	Per hour	2	657.00	14.25	18724.50	
Caregiver Participant Training Total:						5251.62
Caregiver Participant Training	Per need	11	6.00	79.57	5251.62	
Chore Services Total:						84399.12
Chore Services	Per job	72	71.00	16.51	84399.12	
Community Transition Services Total:						19045.68
Community Transition Services	Per transition	24	1.00	793.57	19045.68	
Environmental Accessibility Adaptations (EAA) Total:						674570.40
Environmental Accessibility Adaptations (EAA)	Per job	210	2.00	1606.12	674570.40	
Home-Based Supportive Care Total:						108389541.12
Home-Based Supportive Care	Per hour	8603	772.00	16.32	108389541.12	
Home-Delivered Meals Total:						2137177.20
Home-Delivered Meals					2137177.20	

	Per meal	1460	186.00	7.87		
Personal Emergency Response System (PERS) Total:						1143926.24
Personal Emergency Response System (PERS)	Monthly	4223	8.00	33.86	1143926.24	
Social Adult Day Care Total:						277914.78
Social Adult Day Care	Day	143	59.00	32.94	277914.78	
Specialized Medical Equipment and Supplies Total:						1786608.00
Specialized Medical Equipment and Supplies	Per month	2280	12.00	65.30	1786608.00	
Transitional Care Management Total:						46874.50
Initial	Per transition	209	1.00	212.18	44345.62	
Monthly	Per transition	24	1.00	105.37	2528.88	
Transportation Total:						17168.80
Transportation	Trip	16	55.00	19.51	17168.80	
GRAND TOTAL:						208385239.02
Total Estimated Unduplicated Participants:						14816
Factor D (Divide total by number of participants):						14064.88
Average Length of Stay on the Waiver:						11

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit ^{Co}	Component Cost	Total Cost
Care Management Total:						9561512.94
Initial CM	Initial Month	2002	1.00	218.40	437236.80	
Monthly CM	Monthly	9766	9.00	103.81	9124276.14	
Respite Total:						966723.20
Respite	Day	317	16.00	190.60	966723.20	
Adult Family Care Total:						614020.10
Adult Family Care	Per diem	41	310.00	48.31	614020.10	

Assisted Living (ALR or CPCH) Total:						82984889.16
ALR	Per diem	4008	263.00	64.82	68327021.28	
CPCH	Per diem	1038	251.00	56.26	14657867.88	
Assisted Living Program (ALP) in Subsidized Housing Total:						7315640.32
Assisted Living Program (ALP) in Subsidized Housing	Per diem	523	256.00	54.64	7315640.32	
Attendant Care Total:						28934.28
Attendant Care	Per hour	3	657.00	14.68	28934.28	
Caregiver Participant Training Total:						5900.40
Caregiver Participant Training	Per need	12	6.00	81.95	5900.40	
Chore Services Total:						90525.00
Chore Services	Per job	75	71.00	17.00	90525.00	
Community Transition Services Total:						21251.88
Community Transition Services	Per transition	26	1.00	817.38	21251.88	
Environmental Accessibility Adaptations (EAA) Total:						731200.60
Environmental Accessibility Adaptations (EAA)	Per job	221	2.00	1654.30	731200.60	
Home-Based Supportive Care Total:						117237108.88
Home-Based Supportive Care	Per hour	9034	772.00	16.81	117237108.88	
Home-Delivered Meals Total:						2312469.18
Home-Delivered Meals	Per meal	1533	186.00	8.11	2312469.18	
Personal Emergency Response System (PERS) Total:						1237263.36
Personal Emergency Response System (PERS)	Monthly	4434	8.00	34.88	1237263.36	
Social Adult Day Care Total:						302282.37
Social Adult Day Care	Day	151	59.00	33.93	302282.37	
Specialized Medical Equipment and Supplies Total:						1932245.28
Specialized Medical Equipment and Supplies	Per month	2394	12.00	67.26	1932245.28	
Transitional Care Management Total:						50902.78
Initial	Per transition	220	1.00	218.55	48081.00	
Monthly	Per transition	26	1.00	108.53	2821.78	
Transportation Total:						18793.50

Transportation	Trip	17	55.00	20.10	18793.50	
GRAND TOTAL:					225411663.23	
Total Estimated Unduplicated Participants:					15557	
Factor D (Divide total by number of participants):					14489.40	
Average Length of Stay on the Waiver:						11

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit ^{Co}	Component Cost	Total Cost
Care Management Total:						10340310.00
Initial CM	Initial Month	2103	1.00	224.96	473090.88	
Monthly CM	Monthly	10254	9.00	106.92	9867219.12	
Respite Total:						1042851.84
Respite	Day	332	16.00	196.32	1042851.84	
Adult Family Care Total:						663300.80
Adult Family Care	Per diem	43	310.00	49.76	663300.80	
Assisted Living (ALR or CPCH) Total:						89734621.13
ALR	Per diem	4208	263.00	66.77	73894626.08	
CPCH	Per diem	1089	251.00	57.95	15839995.05	
Assisted Living Program (ALP) in Subsidized Housing Total:						7909816.32
Assisted Living Program (ALP) in Subsidized Housing	Per diem	549	256.00	56.28	7909816.32	
Attendant Care Total:						29801.52
Attendant Care	Per hour	3	657.00	15.12	29801.52	
Caregiver Participant Training Total:						6077.52
Caregiver Participant Training	Per need	12	6.00	84.41	6077.52	
Chore Services Total:						98213.59
Chore Services	Per job	79	71.00	17.51	98213.59	

Community Transition Services Total:						22731.30
Community Transition Services	Per transition	27	1.00	841.90	22731.30	
Environmental Accessibility Adaptations (EAA) Total:						790623.52
Environmental Accessibility Adaptations (EAA)	Per job	232	2.00	1703.93	790623.52	
Home-Based Supportive Care Total:						126751090.20
Home-Based Supportive Care	Per hour	9485	772.00	17.31	126751090.20	
Home-Delivered Meals Total:						2498937.90
Home-Delivered Meals	Per meal	1609	186.00	8.35	2498937.90	
Personal Emergency Response System (PERS) Total:						1338033.20
Personal Emergency Response System (PERS)	Monthly	4655	8.00	35.93	1338033.20	
Social Adult Day Care Total:						325803.90
Social Adult Day Care	Day	158	59.00	34.95	325803.90	
Specialized Medical Equipment and Supplies Total:						2090039.04
Specialized Medical Equipment and Supplies	Per month	2514	12.00	69.28	2090039.04	
Transitional Care Management Total:						54791.33
Initial	Per transition	230	1.00	225.10	51773.00	
Monthly	Per transition	27	1.00	111.79	3018.33	
Transportation Total:						19354.50
Transportation	Trip	17	55.00	20.70	19354.50	
GRAND TOTAL:						243716397.61
Total Estimated Unduplicated Participants:						16335
Factor D (Divide total by number of participants):						14919.89
Average Length of Stay on the Waiver:						11