

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 changes in the document are being viewed in comparison to the current amendment submitted to CMS on December 27, 2007. The questions submitted by CMS to NJ on April 16, 2008 were addressed in the text of this renewal application. These questions include issues of Financial Considerations and Cost Neutrality, Program, Eligibility, and Case Management.

NJ has removed the ITN service from the waiver service option based upon underutilization and availability of the majority of the services through alternate resources. The definition of assistive technology devices proposed in the 2007 amendment has been expanded to include the services of an adaptive equipment lending library and environmental assessment.

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*):
renewal waiver
- C. **Type of Request: renewal**

Migration Waiver - this is an existing approved waiver

Renewal of Waiver:

Provide the information about the original waiver being renewed

Base Waiver Number:

Amendment Number

(if applicable):

Effective Date: (*mm/dd/yy*)

Waiver Number: NJ.0031.R01.00

Draft ID: NJ.06.01.00

Renewal Number:

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

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

Approved Effective Date: 10/01/08

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

- Hospital as defined in 42 CFR §440.10**

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

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

Nursing Facility

Select applicable level of care

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

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

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

Intermediate Care Facility for 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:

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.

This waiver will allow the Division of Developmental Disabilities (DDD) a component of the Single State Medicaid Agency charged with the daily administration of this waiver to provide both self-directed services and provider managed services statewide to individuals currently living with their family, in their own home or in alternate community living arrangements such as group homes and supervised apartments. The Single State Medicaid Agency is the Department of Human Services (DHS). The Designee agency with final responsibility

for oversight is the Division of Medical Assistance and Health Services (DMAHS) a division under the auspices of DHS. The daily administration of the waiver will be conducted by the Division of Developmental Disabilities, a sister agency to DMAHS also under the auspices of DHS.

Participants who self direct as well as individuals entering waiver services and/or who require a significant change in services based upon a change in need will be allocated an Individual Budget based on support need. Individuals who self direct will be assisted in the process by the services of a contracted Support Coordination agency and Fiscal Intermediary. By providing individuals the choice of service delivery via the two options, self-directed services and provider managed services, this waiver offers a broad range of choice and preference in supports. It will facilitate the integration of adults who have completed their public school educational entitlement in their own community and allow individuals who have built a support system in their community to continue to live and work there.

Individual support services will be rendered in residential placements such as group homes; supervised apartments and community care residences (skill homes) as well as through individuals/agencies hired by the service recipient to render services in homes that the individual owns or leases. Other services available to participants in the waiver will include Day Habilitation, Supported Employment, Personal Emergency Response Services (PERS), Environmental/Vehicle Accessibility Adaptations and Assistive Technology Devices.

The State of New Jersey will contract with licensed or authorized providers in accordance with NJ standards approved by CMS in this waiver application. NJ will provide oversight and assistance to individuals and approved providers through Case Managers in the provider managed service system and through Support Brokers/Coordinators and Regional Monitors in the self directed system. NJ will operate a Quality Management system that involves State staff, providers, consumers, family members and other stakeholders or advocates in a process of Continuous Quality Improvement. The goal of this Waiver program is to support individuals in the least restrictive setting in the community and ensure participants health, safety and freedom from exploitation as s/he achieves his/her goals in a manner that allows for the maximization of choice.

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. **Statewidness.** Indicate whether the State requests a waiver of the statewidness requirements in §1902(a)(1) of the Act (*select one*):

- No**
 Yes

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

- Geographic Limitation.** A waiver of statewidness 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 statewidness 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:
- As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 - 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,
 - 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:
- Informed of any feasible alternatives under the waiver; and,
 - 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 Division of Developmental Disabilities as the component of the Single State Medicaid Agency charged with the daily administration of the waiver meets regularly with a representative group of stakeholders, including directors of provider agencies, advocacy groups, and family members of individuals with developmental disabilities, in a forum called "Dialogue with the Division".

In addition, input has been solicited from a composition of the New Jersey Council on Developmental Disabilities. This group consists of people with developmental disabilities, parents or guardians of people with developmental disabilities; nongovernmental service providers and representatives from state agencies that provide services to people with developmental disabilities.

Finally, DDD has utilized a Real Choice Systems Change Grant for QA/AI that was awarded in 2004 to develop a Quality Management Steering Committee of major stakeholders to oversee its Quality Management Strategy. Through this committee DDD has sought input into the plans for data collection, monitoring, analysis and the implementation of a system of Continuous Quality Improvement.

With regard to this amendment, meetings with stakeholders were held on October 29, 2007, November 15, 2007, November 16, 2007, and November 28, 2007. Comments were solicited at the meetings, through telephone conversation and by email. Where appropriate and/or feasible by budget they were addressed in this application.

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:

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

Last Name:

First Name:
Title:
Agency:
Address:
Address 2:
City:
State: **New Jersey**
Zip:
Phone: **Ext:** **TTY**
Fax:
E-mail:

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:
 State Medicaid Director or Designee
Submission Date:

Last Name:
First Name:
Title:
Agency:
Address:
Address 2:
City:
State: **New Jersey**
Zip:
Phone:
Fax:
E-mail:

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

All consumers currently receiving services under the Community Care Waiver (control # - 0031.90R4) will continue to receive services as they are accustomed. Individuals who enter the waiver after the amendment is approved will be assessed by a standardized tool prior to

receiving services. Only those individuals currently receiving services who demonstrate a significant change in service needs will be assessed by the standardized tool. This tool sets specific budgetary limits on waiver services. The budget amounts are “up to amounts”. In this manner, individuals entering services will receive parity in service delivery as their needs are addressed while individuals currently served in the waiver do not experience a disruption in services.

During the Annual Review, the Service Plan and ICF/MR certification of eligibility will be updated. No one will lose services they currently receive by amending the existing Community Care Waiver.

The amended waiver, consistent with CMS philosophy, will allow for more opportunities to self direct and receive services in community integrated non traditional settings as well as enhancing the ability of individuals to transition into the community from institutional settings..

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.

Division of Medical Assistance and Health Services

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

The Single State Medicaid Agency is the Department of Human Services (DHS). A component unit of DHS, the Office of

Program Integrity and Accountability, houses the Developmental Disabilities Licensing Unit (DDL), the Special Response Unit (SRU) an unusual incident investigative unit, and the Critical Information Management Unit (CIMU) that tracks and trends unusual incidents. This component branch of DHS performs critical Quality Oversight in the assurances of Health and Safety, and Provider Qualifications. They provide additional quality functions regarding the other basic assurances, The Designee agency with final responsibility for oversight is the Division of Medical Assistance and Health Services (DMAHS) a division under the auspices of DHS. DMAHS provides critical oversight in the areas of Fiscal assurances. They also review/approve changes in the waiver application, HCFA 372 reports and any other communication necessary through the state to CMS. All applications for changes and/or responses to CMS queries will be processed by DDD through the DMAHS. Issues will be addressed as they occur. In addition, DMAHS has responsibility for the Quality Review of all waiver assurances through annual comprehensive desk audits and specific topic audits.

The daily administration of the waiver is conducted by the Division of Developmental Disabilities, a sister agency to OPIA and DMAHS also under the auspices of DHS. DDD is responsible for securing qualified service providers, oversight of the plan of care, and ensuring delivery of services. DDD does quality management over all of the waiver assurances.

In addition, DDD participates in regular (bi-monthly) meetings with DMAHS and the two other state agencies administering 1915(c) waivers to ensure coordination of activities between the waivers and state plan services.

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

- 3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):
- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
 Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
- No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

- 4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):
- Not applicable**
- Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
 Check each that applies:
- Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.
- Specify the nature of these agencies and complete items A-5 and A-6:*
- Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix A: Waiver Administration and Operation

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

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:

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

Conduct routine, ongoing oversight of the waiver program.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DDD CMS claims 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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" 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: DHS, DMAHS	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Provider records, reports, consumer plans of care, and medical records.

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 checked="" 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 type="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS, Office of Program Integrity & Accountability (OPIA); Developmental Disabilities Licensing (DDL); DMAHS	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: All providers are reviewed annually. With a 10% sampling of documents maintained at the service site based upon highest level of service need. If issues are noted the sampling will increase up to 25%.
	<input checked="" type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Provider Agency Investigative Reports, Unusual Incident Reports and Follow up Reports.

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 checked="" 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: DHS,OPIA; Critical Incident Management Unit (CIMU)	<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: As necessary.	

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Service contracts, expenditure reports, attendance records.

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 checked="" 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: DHS, BRS.	<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: The monthly report follows up with responsible parties re:current status of an investigation. Other reports are generated on an as needed basis. Rates are analyzed and adjusted as necessary.	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Consumer Disability Reports/Documents.

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 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: DHS,DMAHS,Institutional Service Section	<input checked="" 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 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 checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHS,DMAHS;DHS,Office of Program Integrity and Accountability;Developmental Disabilities Licensing;DHS,Critical Incident Management Unit;DHS,Bureau of Rate Setting;DMAHS,Institutional Service Section.	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other

	Specify: The monthly report follows up with responsible parties re: current status of an investigation. Other reports are generated on an as needed basis. Rates are analyzed and adjusted as necessary.
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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 NJ Department of Human Services is the single state Medicaid Agency. Various components of the Department have oversight responsibilities. The Division of Medical Assistance and Health Services (DMAHS) operates as the Department designee. Documentation can be found in the CCW Consumer Review Form (reports from state monitoring reviews conducted) available in DHS, DDD Central Office. The DHS Division of Medical Assistance and Health Services expenditure and eligibility oversight documentation is available in the Management and Administrative Reporting System Reports as well as the Institutional Service Section consumer disability reports and consumer files. The DHS Office of Licensing documentation includes Licensure Inspection Reports, Provisional, Suspension or Termination of Licensure Notification, and Provider Plan of Correction. The DHS Special Response Unit Reports include Unusual Incidents Reports, Incident Follow Up Reports, Investigation Reports including Formal SRU letter titled summary of findings. The Department of Human Services Critical Incident Management Unit database system (including correction report and grid query) also contains significant data regarding investigation of and follow up regarding allegations of abuse, neglect and exploitation. The DHS Bureau of Rate Setting documents include Amended Cost Report Rate Calculation Schedules, Rate Recommendation correspondence to DMAHS and approvals as well as the Final Rate Report.

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.

DMAHS tracks all billing claims, provides reports re: all expenditures on a monthly basis, notifies the DDD of billing abnormalities and/or concerns requiring follow up.

Rate setting reviews all DDD documents and follows up with questions/concerns and/or authorizes the change in rate.

For licensure, provisional licensure is issued (if warranted) requiring an appropriate plan of correction to return to full licensure to be submitted within 30 days of notification. If the agency/service provider remains non-compliant the case may result in a revocation of licensure.

For investigations that result in a substantiated finding of a serious nature may result in a provisional license requiring a plan of correction or a revocation of licensure.

CIMU continues requesting a corrective action plan from agency/service provider if necessary within 30 days. In addition CIMU closes the investigation when the issue is resolved.

DMAHS, ISS unit follows up on concerns re: waiver eligibility on an ongoing basis.

DDD on an ongoing basis addresses individual concerns intermittently as reported and as identified during regularly scheduled case management site visits.

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 checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHS, OPIA, DDL, CIMU and DHS DMAHS	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: As necessary.

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 Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

CMS stated that New Jersey currently substantially meet Assurance V: "State Medicaid Agency Retains Administrative Authority over the Waiver Program" but recommends improvements. I have listed the specific CMS recommendation in bullet form below and the NJ Plan for Compliance beneath that recommendation.

- Develop a process that documents, tracks, and analyzes data to discover state-wide trends and a process for remediation and improvement. The State should describe the process they intend to establish with timeframes.

The Quality Management Unit (QMU) of DMAHS (the designee for the Single State Medicaid Agency), will provide ongoing evaluation and documentation of CMS quality assurance measures to assure that they are met. The QMU Quality Assurance & Improvement framework encompasses scheduled annual comprehensive desk audits, interim targeted desk audits, interim targeted on-site audits, topic audits, and participation in the DDD quality assurance meetings and Interagency meetings. In order to assess follow up and identify trends and/or areas for improvement, collection and analysis of aggregate data will be secured from DDD and the interdepartmental offices of the Single State Medicaid Agency associated with the CCW waiver. Interdepartmental entities responsible to assess the Health & Welfare assurance activities include the component units of the Office of Program Integrity and Accountability (OPIA) including but not limited to the Developmental Disabilities Licensure Unit (OOL) and the Critical Incident Management Unit (CIMU). Entities responsible to assess Qualified Provider assurance activities include the Critical Incident Management Unit (CIMU), Special Response Unit (SRU) and the Training Advisory Committee (TAC). Required documentation associated with Level of Care and Plan of Care assurances will be accessed through the DDD regional offices.

QMU has established an internal Quality Assurance Advisory Committee (QAAC) for the purpose of overseeing QMU program operations, and developing standard guidelines and processes for topic audits. The first meeting was conducted on Monday February 11, 2008.

QMU staff will conduct all desk audits (including annual comprehensive desk audits and specific topic audits) on QMU premises. Staff will send written notice to the DDD regional offices 4-6 weeks in advance of the audits with a copy to DDD central office.

- By May 2008, DMAHS, QMU staff will begin conducting annual comprehensive desk audits and include retrospective reviews of randomly selected waiver participant records and supporting documents for no less than one complete Plan of Care cycle (a minimum of 12 months). The Annual Comprehensive Desk audit will cover the level of care need determinations, the responsiveness of Plans of Care to participant needs, the assurance that individuals receive services from qualified providers, the assurance that health and welfare of waiver participants are addressed, and the assurance that there is appropriate fiscal accountability for payment related to services rendered.

- By January 2009, DMAHS, QMU staff will begin conducting specific topic audits based upon the analysis of information to determine what aspects of the waiver programs require improvement. Desk audits are based on a percentage of the records reviewed by DDD.

Upon completion of any audit, QMU will prepare a written audit report which will be sent to the audited agency within 60 days summarizing general findings, any identified areas requiring remediation as well as agency strengths.

The DDD regional offices will be required to submit a Plan of Correction if documentation of any assurance is lacking in more than 10% of the records audited. Identified areas of non-compliance that have the potential for adversely affecting the health and well-being of participants or functioning of staff are followed up on an urgent basis by QMU administrative staff. For those service providers requiring a Plan of Correction, based on either the QMU audits, OPIA findings or DDD's audit, QMU staff will schedule a follow up interim targeted desk audit to be conducted approximately two months from the date of the submitted and approved Plan of Correction. All interim targeted desk audits include random selection of waiver participant records and supporting documents which assess the components targeted for remediation in the Plan of Correction. The purpose of the interim targeted desk audit is to track continued compliance to the Plan of Correction. Unresolved findings, if noted, on interim targeted audit will require a joint on-site visit (interim focused on-site review) by QMU and DDD staff to reach resolution.

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
<input type="radio"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Disabled (Other)	<input type="text"/>	<input type="text"/>	
<input type="radio"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Mental Retardation or Developmental Disability, or Both					
	<input checked="" type="checkbox"/>	Autism	0	<input type="text"/>	<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Developmental Disability	0	<input type="text"/>	<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Mental Retardation	0	<input type="text"/>	<input checked="" type="checkbox"/>
<input type="radio"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Serious Emotional Disturbance	<input type="text"/>	<input type="text"/>	

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

Participants must meet NJ DDD Eligibility criteria and ICF/MR Level of Care (LOC) as specified in this document. Self Directing participants must have the ability to live with their family, in their own home or with less than 4 unrelated individuals with Support services, not to exceed the total budgetary limit identified in this waiver through the New Jersey Resource Tool. In addition, individuals who choose to self direct must have the ability to do so or designate someone significant (unpaid) to him/her to self direct for him/her.

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

- Not applicable. There is no maximum age limit**
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage:

- Other**

Specify:

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

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

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

- The following dollar amount:**

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
- The following percentage that is less than 100% of the institutional average:**

Specify percent:

- Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

the cost limit:

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

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

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

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	11571
Year 2	12265
Year 3	13001
Year 4 (renewal only)	13781
Year 5 (renewal only)	14608

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	10742
Year 2	11197
Year 3	11652
Year 4 (renewal only)	12107
Year 5 (renewal only)	12562

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).**

Purpose(s) the State reserves capacity for:

Purposes
Emergency Placements
Individuals moving out of a Developmental Center into the community.

Appendix B: Participant Access and Eligibility**B-3: Number of Individuals Served (2 of 4)**

Purpose (*provide a title or short description to use for lookup*):

Emergency Placements

Purpose (*describe*):

Capacity will be reserved for emergency placements.

Describe how the amount of reserved capacity was determined:

The number of slots is based on a reasonable estimate of emergency placements.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	330
Year 2	330
Year 3	330
Year 4 (renewal only)	330
Year 5 (renewal only)	330

Appendix B: Participant Access and Eligibility**B-3: Number of Individuals Served (2 of 4)**

Purpose (*provide a title or short description to use for lookup*):

Individuals moving out of a Developmental Center into the community.

Purpose (*describe*):

Capacity will be reserved for movement from a Developmental Center to the community under the Olmstead or Money Follows the Person (MFP) grant.

Describe how the amount of reserved capacity was determined:

The number of slots is based on a reasonable estimate of individuals scheduled to move out of the Developmental Centers.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	125
Year 2	125
Year 3	125
Year 4 (renewal only)	125
Year 5 (renewal only)	125

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:

Individuals must meet eligibility criteria for both the Division of Developmental Disabilities and ICF/MR Level of Care. Individuals must both request and need a waiver service on a monthly basis.

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:

- The following dollar amount**

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

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

Specify:

- Other**

Specify:

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

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

Specify:

Specify the amount of the allowance (select one):

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The following dollar amount:**

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

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

Specify:

iii. Allowance for the family (select one):

- Not Applicable (see instructions)**
- AFDC need standard**
- Medically needy income standard**
- The following dollar amount:**

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

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

Specify:

- Other**

Specify:

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

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

Select one:

- Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- The State does not establish reasonable limits.**
- The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

- 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:

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

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

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

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

- Directly by the Medicaid agency**
- By the operating agency specified in Appendix A**
- By an entity under contract with the Medicaid agency.**

Specify the entity:

- Other**
Specify:

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

Individuals who perform the initial evaluation of the Level of Care for waiver applicants are required to be a Qualified Mental Retardation Professional (QMRP) as defined in 42 CFR 483.430. This individual (generally the case manager) ensures that the level of care tool is completed by an informant knowledgeable with regard to the individual's capabilities, that the completed tool is consistent with both the QMRP's observations and the skills/needs presented in the individual's plan of care.

- 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.

New Jersey has, with CMS' approval, defined the ICF-MR level of care to mean the recipient has been determined eligible for DDD services in accordance with N.J.A.C. 10:46 and has substantial functional limitations in self-care which require care and /or treatment in an ICF/MR or alternately, in a community program under the DDD Community Care Waiver.

DDD has a Self-Care Assessment tool completed in accordance with the standard agreed upon between DDD and CMS. A QMRP (generally the case manager) ensures that the level of care tool is completed by an informant knowledgeable with regard to the individual's capabilities, that the completed tool is consistent with both the QMRP's observations and the skills/needs presented in the individual's plan of care. The tool and procedure for completion by a DDD QMRP are delineated below:

Consumer Name Date of Birth Serial Number

Initial Certification • Re-Certification • Real Life Choices • (Check Appropriate Box)

Instructions: Check the appropriate boxes according to the individual's needs. Please ensure that the entire document is completed.

Activities of Daily Living Needs Assistance Independent

- Able to use bathtub or shower
- Able to use toilet or bedpan
- Performs hair care (shampooing/combing), shaving, and care of nails
- Transfers from bed to chair (or wheelchair), and transfers in out of the tub or shower
- Demonstrates oral care, such as brushing teeth
- Changes bed linens
- Uses utensils during meals
- Dresses appropriately regarding appearance & climate

- Ambulates, indoors and outdoors
- Prepares simple meals (eggs, sandwiches, cereal/milk)
- Self-administers medication
- Able to use special adaptive equipment

Domestic Skills

- Kitchen: washes dishes, maintains general cleanliness of refrigerator, stove, sink, floor
- Bathroom: maintains cleanliness of toilet, tub, shower and floor
- Uses washing machine and dryer; care for clothes and linens (ironing and mending if necessary)
- Able to clean room and windows: can use a broom, vacuum, and/or window cleaners
- Able to mow lawn, do light painting and minor repairs
- Takes out trash
- Able to obtain needed items from market or pharmacy
- Travels short distances to secure needed items or perform specific tasks

Personal Resources

- Awareness of how nutrition/diet can affect health
- Possesses community living skills such as: money management, home care maintenance, using the telephone, telling time, solving problems, and handling emergencies
- Utilizes community, leisure and recreational activities
- Can access public transportation or specialized services permitting limited community travel and mobility
- Possesses sufficient communication, language and self-advocacy skills to negotiate areas such as citizenship, legal matters, family issues and social needs

Procedure for completion of the
COMMUNITY CARE WAIVER –
SELF CARE ASSESSMENT TOOL FOR WAIVER ELIGIBILITY

In order to be evaluated for waiver eligibility, the Division of Developmental Disabilities (DDD) must have the Self-Care Assessment tool completed in accordance with the standard agreed upon between DDD and the Centers for Medicare & Medicaid Services (CMS). The subsequent procedures should be followed by a DDD Qualified Mental Retardation Professional (QMRP):

1.) When an Expected Admission to Waiver Services form is generated, the Case Manager or Regional Monitor will ensure that a person familiar with the consumer (e.g.; agency staff, DDD staff, family member, etc.) completes the Self Care Assessment Tool*, signs and dates it and then returns it to the consumer's DDD Case Manager or Regional Monitor.

2.) Upon return of the tool, DDD will have a QMRP (e.g. Psychologist, HPC) review the form for accuracy and sign it certifying that the individual reviewed the document.

3a.) If there are no deficits noted then the process ends and the form will be returned to the Case Manager or Regional Monitor with a brief explanation.

3b.) If the QMRP notes deficits/areas in which assistance is needed, then the QMRP will sign the ICF-MR Certification in addition to the Self Care Assessment Tool, verifying certification.

4.) Both signed forms (Self Care Assessment Tool and ICF-MR Certification document) are forwarded to the Case Manager or Regional Monitor with a copy sent to the Regional Fiscal Coordinator who handles waiver eligibility.

5.) At the time of the annual service plan (e.g., ELP, IHP), the Self Care Assessment Tool must be reviewed and updated for all individuals who are waiver eligible. A QMRP must sign the last page of the service plan document, certifying continued ICF-MR (waiver) eligibility if she/he notes deficits/areas in which assistance is needed. If no deficit/area in which assistance is needed is noted, the QMRP will notify the Regional Fiscal Coordinator who handles waiver eligibility to remove the individual from the waiver.

6.) A copy of all signed tools will be maintained in the client file in accordance with Division Circulars.

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.

The NJ Self Care Assessment tool is used to determine Level of Care for waiver services. As previously mentioned, this tool is developed to assess self care deficits. In contrast, institutional care (ICF-MR) eligibility is determined by the professional assessment of a medical doctor (MD). For individuals under the age of 13 years old the DDD will rely on the professional judgment of the QMRP to determine the individual's level of care.

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

The Reevaluation of Level of Care is completed by a Case Manager or a Regional Monitor annually, using the NJ Self Care Assessment (SCA) tool. The reevaluation is completed at the time of the approval of a new service plan by the Case Manager or Regional Monitor.

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

- Every three months
- Every six months
- Every twelve months
- Other schedule

Specify the other schedule:

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

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

Specify the qualifications:

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

timely reevaluations of level of care (*specify*):

A QMRP oversees completion of a new Service Plan and a Reevaluation of Level of Care annually. The recertification document is embedded in the service plan. Currently this reminder and monitoring function is provided through lists of upcoming Annual Service Plan due dates. Area Supervisors monitor the timely completion of the Service Plan and recertification. DDD is overseeing the development of an "Alerts Engine" within the DDD electronic database that will send an alert to each QMRP 60 days in advance of the date a new Service Plan and LOC evaluation is due. A second alert will be sent 30 days in advance. If the due date passes without a new Service Plan being entered into the database, an Alert will be sent to the Case Manager or Regional Monitor and to the Area Supervisor who has supervisory responsibility over the Case Manager or Regional Monitor. If no Service Plan is entered by 30 days past the due date, an alert will be sent to the Area Supervisor and the County Administrator who has supervisory responsibility over the Area Supervisor. If the plan is 60 days overdue an alert will be sent to the Case Manager, the Area Supervisor, the County Administrator and the Regional Administrator who has supervisory responsibility over the County Administrator. The, DDD Regional Administrators understand that the Annual Service Plan, the Medicaid re-determination and the Reevaluation of Level of Care are linked and therefore an overdue date for one is the overdue date for all. Regional Office Administrators monitor this process closely. Reports of Timeliness for Annual Reevaluations, Medicaid Re-determinations and completions of Annual Service Plans will be used as management tools to improve and maintain this process.

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

The records are maintained as part of the official individual client record in each DDD Regional office or satellite office.

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:

An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Regional and agency files and records.

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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" 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: DHS, DDD	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: The Regional Monitor (RM) review 24 cases on a random basis in a region each month ensuring that each region is reviewed 3 times within the year.
	<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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHS, DDD	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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:

Enrolled participants are reevaluated at least annually or as specified in the approved waiver.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Regional and agency files and records. The Recertification document is embedded in the Plan of Care/IHP.

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

ISS consumer files, fiscal information (e.g. bank accounts, earnings, assets) disability documentation (for individuals to covered by SSI or SSDI).

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 checked="" 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 type="text"/>
<input checked="" type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: The Regional Monitor will review 24 cases on a random basis ensuring each region is reviewed 3 time within the year.
	<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 checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHS, DMAHS, ISS; DHS,DDD	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: DHS, DMAHS, ISS,DDD

- 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 process and instruments described in the approved waiver are applied to determine level of care.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Regional and agency files and records.

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 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: DHS, DDD	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: The Regional Monitor will review 24 cases on a random basis in a region each month rotating regions so that each region is reviewed three times within a year.
	<input type="checkbox"/> Other Specify:	

	<input style="width: 90%;" type="text"/>	
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Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Job Description, Job Application, Degree, Resume

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 checked="" 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 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 style="width: 80%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 80%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 80%;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: The Regional Monitor will review 24 cases on a random basis in a region each month rotating regions so each region is reviewed 3 times within the year.
	<input type="checkbox"/> Other Specify: <input style="width: 80%;" 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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHS, DDD	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 80%;" type="text"/>

- 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.
By July 2008, as a proactive measure, DDD will develop an automatic electronic notification process that informs the Case Manager (QMRP) and his/her supervisor of the status of LOC assessments. Alerts will advise of LOCs due within 60 days and LOCs overdue by 30 days.

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.
On a monthly basis the Waiver Monitor will contact the Regional Administrator with a list of deficiencies regarding level of care determinations. The Regional Administrator will respond with a plan of correction for the individual issue as well as a systemic response where the issue is more than an isolated case. The documentation shall be in the form of electronic emails. On a monthly basis the Case Management Supervisor will document any concerns and ensure that the case manager address them.

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 checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHS,DDD; DMAHS ISS Office	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" 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 Financial Accountability 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.

- Develop a uniform methodology for monthly random sampling and analysis of client reviews.

By July 1, 2008 DDD will have created an uniform system of random sampling and analysis of client reviews for two (2) tiers of oversight:

- a. Case Management Supervisors.
- b. Community Care Waiver Monitor.

- Develop a tracking database to identify the timeliness and frequency of level of care evaluations.

a. By July 1, 2008, as a proactive measure, DDD will develop an automatic electronic notification process that informs the Case Manager (QMRP) and his/her supervisor of the status of LOC assessments. Alerts will advise of LOCs due within 60 days and LOCs overdue by 30 days.

b. By October 1, 2008 DDD will have developed an electronic platform to begin tracking two tiers of oversight.

i. An electronic platform will be developed to allow the Case Management Supervisors to review a five percent sampling of LOC assessments monthly to document both: whether the standard for timeliness has been met and that the LOC assessment tool is completed and verifies the accuracy of the certification/recertification.

ii. An electronic platform will be developed to allow the Community Care Waiver Monitor to review 268 cases annually that document both: the frequency with which the standard for timeliness has been met and the percentage of times the LOC assessment tool is completed and verifies the accuracy of the certification/recertification.

- Maintain a reporting mechanism for monthly, quarterly, and/or annual reviews of level of care tracking.

By January 1, 2009 DDD will begin a system of quarterly reports aggregating and analyzing the two tiers of oversight for timeliness and appropriateness of reviews of LOC.

- Develop a trending analysis of provider compliance with this requirement and remedial follow up if necessary.

By January 1, 2009 DDD will have a process in place to conduct trend analysis of timeliness and appropriateness of level of care determinations compliance by region and will track remediation should issues be identified. This analysis will be completed on two tiers: both the case management supervisory level and the Community Care Waiver Monitor.

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).

During the waiver application process, the Case Manager or Regional Monitor will verbally offer information about the services that are available under the waiver. S/he will also inform the applicant or guardian of the option to choose institutional or home and community based services.

Applicants/guardians will designate his/her choice of community services or institutional care on the Freedom of Choice form by providing a check in the appropriate area and then signing the form. All applicants will be advised that they have the right to change this decision at any time and/or request a fair hearing. In addition, notification regarding the right to change or reverse the decision is imbedded in the form as is the right to a fair hearing.

The completed Freedom of Choice form will be maintained for a minimum period of three years after the end of the waiver year when the individual entered the waiver. This record will be readily retrievable from the client record which is managed by the Case Manager or the Regional Monitor until/unless the individual elects to choose the option of receiving institutional services. At that time the client records will be transitioned to the developmental center in which the individual is placed.

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

The records will be maintained as part of the official individual client record in each DDD Regional office or satellite office.

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 Division of Developmental Disabilities uses Over-the-Phone Interpreter and Document Translation Services through a contract with Language Line Services in order to best serve the diverse New Jersey population.

Appendix C: Participant Services

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

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

Service Type	Service
Statutory Service	Case Management
Statutory Service	Day Habilitation
Statutory Service	Individual Supports
Statutory Service	Respite
Statutory Service	Supported Employment
Supports for Participant Direction	Community Transition Services
Supports for Participant Direction	Support Coordination
Other Service	Assistive Technology Devices
Other Service	Environmental and Vehicle Adaptations
Other Service	Personal Emergency Response System (PERS)
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):

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 receive waiver services in gaining access to needed waiver and specific State Plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:**Service Delivery Method (check each that applies):**

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Community Program Specialist
Individual	Senior Community Program Specialist
Individual	Habilitation Plan Coordinator

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

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Individual

Provider Type:

Community Program Specialist

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (*specify*):

1. Must meet the qualifications for a QMRP.
2. Must have a Bachelor's degree.
3. Must pass criminal background check.
4. Must qualify for and pass a NJ Civil Service Test.
5. Must be employed in position.

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

DHS, DDD, Personnel Unit, and Department of Personnel

Frequency of Verification:

At initial application.

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

Senior Community Program Specialist

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

1. Must meet the qualifications for a QMRP.
2. Must have a Bachelor's degree.
3. Must pass criminal background check.
4. Must qualify for and pass a NJ Civil Service Test.
5. Must be employed in position.

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

DHS, DDD, Personnel Unit, and Department of Personnel

Frequency of Verification:

At initial application.

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

Habilitation Plan Coordinator

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

1. Must meet the qualifications for a QMRP.
2. Must have a Bachelor's degree.
3. Must pass criminal background check.
4. Must qualify for and pass a NJ Civil Service Test.

5. Must be employed in position.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS, DDD, Personnel Unit, and Department of Personnel

Frequency of Verification:

At initial application.

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:

Day Habilitation

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):

Day Habilitation is the process of providing those comprehensive services that are deemed necessary to meet the needs of individuals with developmental disabilities in individual programs and services designed to achieve objectives of improved health, welfare and the realization of individuals' maximum physical, social, psychological and vocational potential for useful and productive activities. Although the specific services will be described in an individual's Service Plan, habilitation services are designed to develop, maintain and/or maximize the individual's independent functioning in self-care, physical and emotional growth, socialization, communication, and vocational skills. Day Habilitation services may include the following:

- A. Developing socially appropriate behaviors and interpersonal skills, and eliminating maladaptive behaviors;
- B. Developing cognitive skills including, but not limited to, the handling of emergencies, telling time, managing money, making change, recognizing street and other signs, solving problems, etc.;
- C. Using recreation and leisure time;
- D. Orienting to the community and training for mobility and travel;
- E. Developing or remediating communication skills;
- F. Developing appropriate grooming, sex, dress, and self-care habits, such as toileting, eating, and shaving;
- G. Enhancing the physical, mental, and dental health of persons served. The services should deal with prevention and maintenance needs.
- H. Training in assertiveness, and advocacy in dealing with citizenship, legal, family, and/or social needs; and,
- I. Orienting to other programs, as appropriate.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, and between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

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

For purposes of this waiver, day habilitation does not include services, activities or training

to which the client may be entitled under federal or state programs of public elementary or secondary education, state plan services or federally aided vocational rehabilitation.

Transportation as defined above will be provided to service recipients from their place of residence or pick up/drop off site to the habilitation site within 38 miles and/or for a total of one hour and fifteen minutes one way, based upon whichever limit is reached first.

Day Habilitation Services are limited to a total of 25 hours per week. When an individual elects to utilize both Day Habilitation Services and Adult Day Health Services (State Plan) the combination of hours per week cannot exceed 25 hours and the majority of those hours must be in a Day Habilitation Service.

The state will make retainer payments for providers of Habilitation when the waiver participant is hospitalized or absent from his/her home for a period of no more than 30 consecutive days. For hospital absences and related absences (e.g., rehabilitation time in a rehabilitation unit), the individual plan does not need to reflect the absence. For all other absences, the individual plan shall reflect the need for the absence from the home.

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 Activities Center
Agency	Other Agencies
Individual	Habilitation Assistant
Agency	Extended Employment
Agency	Agencies authorized to render habilitation services in Pennsylvania

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Adult Activities Center

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Supported Employment and Day Program Manual

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services (DHS), Division of Developmental Disabilities (DDD) – Office of Quality Improvement

Frequency of Verification:

Annually through random sample of 20% of total contracted entities. 100% to be achieved in 5 years. Cycle to begin again in year 6.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:Agency **Provider Type:**

Other Agencies

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

These agencies must be in compliance with the accepted standards for state, community and local businesses and laws regarding businesses.

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

Division of Developmental Disabilities, Office of Housing and Resource Development

Frequency of Verification:

At the time of initial application

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:Individual **Provider Type:**

Habilitation Assistant

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

1. Must be at least 18 years of age
2. Have the ability/experience to meet the participant's needs as expressed in a written job description developed by the individual. This job description will become the basis of the contract for service if applicant is hired.
3. Have the physical capacity to perform the job functions as required by the participant.
4. Have the ability to communicate in the individual's primary language.
5. Pass criminal history background check.
6. Pass drug and alcohol screen if required by employer of record.
7. If job requires driving, a valid driver's license and a copy of the abstract of the driver's record.
8. Reference check of two most recent employers.
9. Completion of any additional training specified by individual.
10. Attend mandatory one-day new hire orientation program if required by the employer of record.

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

Department of Human Services (DHS), Division of Developmental Disabilities (DDD)

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:Agency **Provider Type:**

Extended Employment

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Supported Employment and Day Program Manual

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

Department of Human Services (DHS), Division of Developmental Disabilities (DDD) – Office of Quality Improvement

Frequency of Verification:

Annually through random sample of 20% of total contracted entities. 100% to be achieved in 5 years. Cycle to begin again in year 6.

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

Agencies authorized to render habilitation services in Pennsylvania

Provider Qualifications**License (specify):**

Title 55 PA Code: Chapter 2380

Certificate (specify):**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

Department of Human Services, Division of Developmental Disabilities

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:Statutory Service **Service:**Personal Care **Alternate Service Title (if any):**

Individual Supports

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):

Individual support services are self-care and habilitation-related tasks performed and/or supervised by service provider staff in an individual's own or family home or in other community-based settings, in accordance with approved Service Plans. Assistance to, as well as training and supervision of, individuals as they learn and perform the various tasks that are included in basic self-care, social skills, activities of daily living and behavior shaping will be provided. (The Service Plan will specify the actual tasks to be performed and the anticipated outcomes).

Individual support services may include:

A. Personal Assistance

Personal assistance means assistance with normal personal maintenance and household care activities at the direction of the recipient of services, his/her family member or guardian, in accordance with an established Service Plan. Personal Assistance services include attendant care, specified household chores, assistance with shopping appointments or other errands essential to community integration. The purpose of personal assistance is to provide necessary support for eligible people to meet their daily living needs and improve integration into the community.

Personal assistance services are described as follows:

1. Attendant Care Services:

- a. Bathing in bed, in the tub, or shower;
- b. Using toilet or bedpan;
- c. Grooming: care of hair, including shampooing, shaving and the ordinary care of nails;
- d. Helping individual in transferring from bed to chair or wheelchair, in and out of tub or shower;
- e. Care of teeth and mouth;
- f. Changing bed linens with recipient in bed;
- g. Helping with eating and preparing meals, including special therapeutic diets for the recipients;
- h. Dressing;
- i. Ambulation, indoors and out;
- j. Escorting recipient to clinics, physician's office, related medical therapies, recreation activities and/or other trips;
- k. Assisting with medication that can be self-administered;
- l. Assisting recipient with use of special equipment such as walker, braces, crutches, wheelchair, etc., after thorough demonstration by a registered professional nurse or physical therapist, with return demonstration until registered professional nurse or physical therapist is satisfied that the individual can use equipment safely;
- m. Assisting individual in implementing physical or occupational therapy, speech language pathology programs or psychological/behavioral programs.

2. Household Chores:

- a. Care of kitchen, including maintenance of general cleanliness of refrigerator, stove, sink, and floor, dishwashing;
- b. Care of bathroom, including maintaining cleanliness of toilet, tub, shower, and floor;
- c. Care of recipient's personal laundry and bed linen (may include necessary ironing and mending);
- d. Bed making and changing of bed linen;
- e. Window washing;
- f. Lawn cutting;
- g. Putting out garbage;
- h. Other necessary household chores related to independent living.

3. Errand Services:

- a. Routine errands for recipient such as picking up medication, picking up prepared meals, shopping, or any short trip to perform a specific task.

B. Training

Training services are activities intended to assist a recipient in acquiring, maintaining, or improving skills and/or knowledge. This training is intended to assist a recipient to achieve or maintain independence in the performance of routine, daily tasks. It is also intended to assist a recipient in accessing and utilizing community resources and to enhance community integration.

Qualifying services include:

- 1. Training in self-care activities such as grooming, bathing, toileting, shaving, dressing, and feeding.
- 2. Training in nutrition, diet, and food purchase and preparation.
- 3. Training in community living skills such as money management, home care maintenance, using the telephone, telling time, solving problems, and handling emergencies.
- 4. Training in leisure/recreation activities and using recreational opportunities.
- 5. Training in family, psycho/social and life activities.

- 6. Training in travel activities, such as utilizing public transportation, utilizing specialized services, achieving mobility within the neighborhood, and employing reasonable safety precautions.
- 7. Training in decision-making, assertiveness and self-advocacy in dealing with citizenship, legal, family, and/or social needs.
- 8. Developing or remediating communication skills including training in receptive language, expressive language, vocabulary development, sign language, conversation, expressing feelings and using communication devices.
- 9. Training in medication management and self-administration.
- 10. Training in mobility, including the use of adaptive devices.

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

Individual Support providers may be members of the individual's family. Payment will not be made for services furnished by the individual's parent (or stepparent), spouse, or by a guardian, legally responsible relative or relative residing in the service recipient's residence with the following exception. Relatives residing in the individual's home will be permitted to render services for a period of no more than 30 days annually at no more than 40 hours/week, during transition/hiring of new staff.

The state will make retainer payments for providers of Individual Support, except for members of the individual family, when the waiver participant is hospitalized or absent from his/her home for a period of no more than 30 consecutive days. For hospital absences and related absences (e.g., rehabilitation time in a rehabilitation unit), the individual plan does not need to reflect the absence. For all other absences, the individual plan shall reflect the need for the absence from the home.

Justification:

Family members who provide Individual Support services must meet the same standards as providers who are unrelated to the individual.

Supervision of Individual Support providers will be furnished by:

Case Managers (by monitoring the Service Plan).

Other

- a. Annual licensing inspection for licensed providers.
- b. Consumer surrogate.
- c. Monitors of Service Plan.

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	Community Care Residence (CCR) Provider
Individual	Mentor/Trainer
Individual	Individual Assistant/Live-In Caregiver
Agency	Contracted Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Individual Supports

Provider Category:

Individual

Provider Type:

Community Care Residence (CCR) Provider

Provider Qualifications

License (specify):

NJAC 10:44B

Certificate (specify):

Other Standard (specify):

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

Department of Human Services, Office of Program Integrity and Accountability, Developmental Disabilities Licensing

Frequency of Verification:

At initial screening and annually thereafter.

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

Mentor/Trainer

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

1. Must be at least 18 years of age.
2. Ability to read and write English sufficiently to perform the duties of the job.
3. Have the ability to communicate in the individual's primary language.
4. Must have documented ability/experience/education in a specific skill area required to meet the participant's needs as detailed in the Service Plan.
5. Must have a signed service contract for the provision of a specific service detailed in the Service Plan, with a specified timeframe.
6. Pass criminal history background check.
7. Pass a drug and alcohol screen if required by the employer of record.
8. Successful completion of any additional training specified by the individual/ surrogate as necessary to perform job functions.

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

Division of Developmental Disabilities, Office of Housing and Resource Development

Frequency of Verification:

Upon employment and annually thereafter.

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

Individual Assistant/Live-In Caregiver

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

1. Must be at least 18 years of age
2. Have the ability/experience to meet the participant's needs as expressed in a written job description developed by the individual. This job description will become the basis of the contract for service if applicant is hired.
3. Have the physical capacity to perform the job functions as required by the participant.
4. Have the ability to communicate in the individual's primary language.

5. Pass criminal history background check.
6. Pass drug and alcohol screen if required by employer of record.
7. If job requires driving, a valid driver's license and a copy of the abstract of the driver's record.
8. Reference check of two most recent employers.
9. Completion of any additional training specified by individual.
10. Attend mandatory one-day new hire orientation program if required by the employer of record.

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

Division of Developmental Disabilities, Office of Housing and Resource Development

Frequency of Verification:

At initial screening and annually thereafter.

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

Contracted Agency

Provider Qualifications**License (specify):**

NJAC 10:44 A and/or NJAC 10:44C or Title 55 PA Code; Chapter 6400

Certificate (specify):**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**Department of Human Services, Office of Program Integrity and Accountability; Developmental Disabilities Licensing;
Division of Developmental Disabilities**Frequency of Verification:**

At initial screening and annually thereafter.

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):

Respite Provider Standards

Respite care is a service provided to individuals in the temporary absence or disability of a parent, guardian, or other immediate

caregiver in accordance with guidelines developed by the Division of Developmental Disabilities. Respite services may be furnished either at the business location or private home of the provider, in the home of the individual with developmental disabilities, or in a location approved by the individual and or his/her legal guardian.

Respite services may be:

A. Furnished by agencies and/or individuals who are licensed under the provisions of New Jersey Administrative Code 10:44A, 10:44B, and/or 10:44C (Manuals of Standards for Licensed Group Homes and Supervised Apartments for the Developmentally Disabled, Standards for Skill Development Homes, Family Care Homes, and Family-Based Respite Care Homes, Standards for Community Residences for Persons with Head Injuries respectively).

B. Furnished by agencies authorized by the New Jersey Department of Health and Senior Services to provide camp services under New Jersey Administrative Code 8:25.

C. Furnished by Intermediate Care Facilities for the Mentally Retarded (ICF-MR) certified in accordance with the Code of Federal Regulations: Title 42 Part 442 Subpart C.

D. Furnished by home health agencies that are authorized Title XIX providers and/or are licensed by another State agency.

E. Furnished by agencies and/or individuals who are approved by, and under contract with, DDD.

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

Providers who are authorized by DDD (rather than licensed), with the exception of camps authorized by the New Jersey Department of Health and Senior Services under N.J.A.C. 8:25, are not authorized to provide overnight services except when the service is provided in the individual's own home.

When furnished by providers who are not approved to provide overnight care, respite services may not include room and board. Board is defined as three meals a day. Room and board is only paid in licensed, certified or authorized residential facilities as indicated above (i.e. A., B., and C), not in the recipient's home.

Respite providers who are approved by the DDD may be members of the individual's family with the following qualifying statement. Payment will not be made for services furnished by the individual's parent (or stepparent), spouse, or by a guardian, legally responsible relative or relative residing in the service recipient's residence.

Justification:

Family members who provide Respite services must meet the same standards as providers who are unrelated to the individual.

Supervision of Respite providers will be furnished by:

Case Managers (by monitoring the service plan).

Other

- a. Annual licensing inspection for licensed providers.
- b. Consumer surrogate.
- c. Monitors of Service Plan.

Facility based respite staff: consumer ratio shall not exceed 1:6.

To further promote the normalization standard, staff: consumer ratio for community off-site respite activities shall not exceed 1:4.

The Division limits Respite Services in ICF-MR facilities to no more than thirty (30) consecutive days at any one time.

Note that except as otherwise provided in the Rehabilitated Offenders Act, no contract will be issued to any person who, at any time, has been convicted of forgery, embezzlement, obtaining money under false pretenses, extortion, criminal conspiracy to defraud, crimes against the person, or other like offense(s). Additionally, no contract shall be issued to an individual who has been civilly adjudged or criminally liable for abuse of another person.

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 Provider: (for individuals with Traumatic Brain Injury) Group Home, Supervised Apartments
Agency	Certified Intermediate Care Facilities for the Mentally Retarded (ICF-MR)
Individual	Authorized CCR Provider
Individual	Licensed CCR Provider (Sponsor Home)
Agency	Licensed Provider: Group Home, Supervised Apartments
Agency	Authorized Camps
Agency	Authorized Title XIX providers (Home Health Agency)

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 Provider: (for individuals with Traumatic Brain Injury) Group Home, Supervised Apartments

Provider Qualifications

License (specify):

N.J.A.C. 10:44C

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services (DHS), Office of Program Integrity and Accountability (OPIA), Developmentally Disabled Licensing (DDL)

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Certified Intermediate Care Facilities for the Mentally Retarded (ICF-MR)

Provider Qualifications

License (specify):

Certificate (specify):

Title 42 Part 442 Subpart C

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Senior Services

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service**Service Name: Respite**

Provider Category:Individual **Provider Type:**

Authorized CCR Provider

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Respite providers who are approved by the DDD must:

1. Be eighteen or older.
2. Pass a background check.
3. Attend mandatory one-day new hire orientation program if required by the employer of record.
4. Meet all state and local codes regarding the facility in which the service is rendered.
5. Complete any additional training specified by individual.

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

Department of Human Services (DHS), Division of Developmental Disabilities (DDD)

Frequency of Verification:

At initial screening.

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 CCR Provider (Sponsor Home)

Provider Qualifications**License (specify):**

N.J.A.C. 10:44B

Certificate (specify):**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

Department of Human Services (DHS), Office of Program Integrity and Accountability (OPIA), Developmentally Disabled Licensing (DDL)

Frequency of Verification:

Annually

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 Provider: Group Home, Supervised Apartments

Provider Qualifications

License (specify):

N.J.A.C. 10:44A

Certificate (specify):**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

Department of Human Services (DHS), Office of Program Integrity and Accountability (OPIA), Developmentally Disabled Licensing (DDL)

Frequency of Verification:

Annually

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

Authorized Camps

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Authorized by the New Jersey Department of Health and Senior Services under N.J.A.C. 8:25.

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

Department of Health and Senior Services

Frequency of Verification:

Annually

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

Authorized Title XIX providers (Home Health Agency)

Provider Qualifications**License (specify):**

N.J.A.C. 8:42

Certificate (specify):

Certified by the New Jersey Department of Health and Senior Services as a home health agency under Title XVIII (Medicare Program)

Other Standard (specify):**Verification of Provider Qualifications****Entity Responsible for Verification:**

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:

Statutory Service

Service:

Supported Employment

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):

SUPPORTED EMPLOYMENT

Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, and between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

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

When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.

Documentation will be maintained in the file of each individual receiving this service that:

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

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

Transportation as defined above will be provided to service recipients from their place of residence or pick up/drop off site to the habilitation site within 38 miles and/or for a total of one hour and fifteen minutes one way, based upon whichever limit is reached first if the service is not available through another source at no cost to the individual.

Note that if the individual self directs or has an individual budget s/he can elect to fund the transportation through the non medical transportation service if it is more cost effective.

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	Job Coach
Agency	Supported Employment Agency

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Individual

Provider Type:

Job Coach

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

Supported Employment and Day Program Manual

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

Department of Human Services, Division of Developmental Disabilities

Frequency of Verification:

Annually

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Supported Employment Agency

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

Supported Employment and Day Program Manual

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

Department of Human Services, Division of Developmental Disabilities

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:

Supports for Participant Direction ▼

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

Support for Participant Direction:

Other Supports for Participant Direction ▼

Alternate Service Title (if any):

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 Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable 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 home accessibility adaptations; and, (g) activities to assess need, arrange for and procure need resources.

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

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 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. The total cost of this service shall not exceed \$10,000.00. Exceptions may be made for issues of health and safety.

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	Other Business Entity
Agency	Utility Companies
Agency	State of New Jersey Vendor

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

Service Type: Supports for Participant Direction
Service Name: Community Transition Services

Provider Category:

Agency ▼

Provider Type:

Other Business Entity

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

License, certification, registration, or authorization from the New Jersey Department of Consumer Affairs (NJCA) or any other endorsing entity and Liability Insurance.

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

Division of Developmental Disabilities, Office of Housing and Resource Development

Frequency of Verification:

At the time initial services are rendered

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Supports for Participant Direction****Service Name: Community Transition Services****Provider Category:**Agency **Provider Type:**

Utility Companies

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Meets the qualifications of state, county and local municipality.

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

Division of Developmental Disabilities, Office of Housing and Resource Development

Frequency of Verification:

Annually

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Supports for Participant Direction****Service Name: Community Transition Services****Provider Category:**Agency **Provider Type:**

State of New Jersey Vendor

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Contract with the State of New Jersey, Division of Medical Assistance and Health Services and Liability Insurance

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

Division of Developmental Disabilities, Office of Housing and Resource Development

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:

Supports for Participant Direction ▼

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

Support for Participant Direction:

Information and Assistance in Support of Participant Direction ▼

Alternate Service Title (if any):

Support Coordination

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):

Support Coordination is a facilitative process that assists individuals and families through the process of self-direction, currently known as Self Determination and Real Life Choices, and empowers them to remain in charge of the plan. The SC introduces families to the ELP process and assist with accessing services and supports.

The SC is responsible for providing information about the range of services and supports offered through the waiver in advance and during the ELP meeting.

The services include but are not limited to:

- attendance at an orientation session conducted by the Regional Monitor where families learn about the ELP
- making initial contact with the individuals and their families to identify their Support Coordination role
- arranging follow up meetings, both group and individual to continue development of the Service Plan
- assisting families in the ELP process
- working with the individuals and their family and the mentors in identifying outcomes
- ensuring that the Service Plan addresses health and safety issues
- assisting in identifying, through the Qualifying Individuals & Agency Process, services and supports that would achieve the individual's stated outcomes and are qualified as providers of waiver services
- assisting families in assuring that services they have identified will really meet outcomes
- presenting need for specialty service to team, if the need to develop a specialized plan for supported employment or housing is identified by family
- mediating between families and providers to insure that families have been given the supports and services based on identified outcomes, not based on what program may be available
- assist in using the budget to achieve outcomes
- insure that supports and services identified are in the correct waiver category
- assist and facilitate Learning Communities
- enter all data into the electronic record and send to family for approval
- make revisions to the plan as requested by families participate as a member of team in annual renewal process

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person

- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Support Coordination
Individual	Support Coordinator (Individual)

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

Service Type: Supports for Participant Direction
Service Name: Support Coordination

Provider Category:

Agency

Provider Type:

Agency Support Coordination

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

1. Must be at least 18 years of age.
2. Pass a criminal background check.
3. Have staff which are diverse and include family members of individuals with disabilities as well as racial and ethnic minorities.
4. Demonstrate that in areas with significant numbers of non-English speaking residents, efforts are made to hire staff that speaks the language of the participants/families or interpreters, i.e. language line.
5. All staff must be trained in Essential Lifestyle Planning (ELP) and as part of the hiring/probationary process; staff must be able to demonstrate, through the development of a Service Plan, an acceptable level of comprehension.

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

Department of Human Services (DHS), Division of Developmental Disabilities (DDD)

Frequency of Verification:

Annually

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

Service Type: Supports for Participant Direction
Service Name: Support Coordination

Provider Category:

Individual

Provider Type:

Support Coordinator (Individual)

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

1. Must be at least 18 years of age.
2. Pass a criminal background check.
3. Be trained in Essential Lifestyle Planning (ELP) and able to demonstrate, through the development of a Service Plan, an acceptable level of comprehension.
4. Have the ability to communicate in the individual's primary language.
5. Pass drug and alcohol screen if required by employer of record.

6. Completion of any additional training specified by individual.
7. Attend mandatory one-day new hire orientation program if required by the employer of record.

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

Department of Human Services (DHS), Division of Developmental Disabilities (DDD)

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:

Assistive Technology Devices

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):

Assistive Technology services allows individuals to access community services. The service is comprised of three components: assessment for the service; loaned use of equipment; and purchase of, modification to, or creation of assistive technology items. The assessment for the need for service is rendered in the environment in which the individual lives and/or works (e.g., own home, group home, day habilitation site, etc.) and will be performed by an appropriate professional. The waiver will be used as a funding mechanism for the assessment only if the assessment is for items not covered under the Medicaid state plan. The use of a lending "library" of technology devices will be used to test different items prior to purchase, modification or creation.

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

An assessment for the need for assistive technology can be performed if the IDT agrees that the need may exist. The lending library can be used for a total of up to three (3) months in a calendar year period if loaned items cannot be secured from the prospective equipment dealers. Assistive technology purchases (including the purchase of new equipment, modification costs to new or already owned equipment, or cost of supplies for created equipment) cannot exceed \$11,000 in a rolling three year period in combination with Environmental/Vehicle Accessibility Adaptations except where issues of health and safety would be compromised. Items covered by the Medicaid state plan cannot be purchased through this benefit.

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	Rehabilitation Technician
Individual	Assistive Technology Specialist
Agency	Medicare Provider
Individual	Physical Therapist

Agency	State of New Jersey Vendor
Individual	Occupational Therapist
Agency	Other Business Entity
Agency	Medicaid Provider
Individual	Speech/Language Pathologist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology Devices

Provider Category:

Individual

Provider Type:

Rehabilitation Technician

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

High school graduate or equivalent with a minimum two years experience working with individuals with disabilities. In addition, experience working with stationary and hand held power tools is required.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services (DHS), Division of Developmental Disabilities (DDD)

Frequency of Verification:

Initially and at time of license renewal and insurance renewal.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology Devices

Provider Category:

Individual

Provider Type:

Assistive Technology Specialist

Provider Qualifications

License (specify):

Certificate (specify):

Must either possess an Assistive Technology Practitioner certificate from the Rehabilitation Engineering and Assistive Technology Society of North America (also known as RESNA) or qualify to sit for the test.

Other Standard (specify):

Bachelor's degree in technical services or rehabilitation services related field and a minimum of one-year experience working with individuals with disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services (DHS), Division of Developmental Disabilities (DDD)

Frequency of Verification:

Initially and at time of license renewal and insurance renewal.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology Devices

Provider Category:Agency **Provider Type:**

Medicare Provider

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Contract with the State of New Jersey, Division of Medical Assistance and Health Services and Liability Insurance

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

Department of Human Services (DHS), Division of Developmental Disabilities (DDD), Office of Housing and Resource Development

Frequency of Verification:

Annually

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

Service Type: Other Service
Service Name: Assistive Technology Devices

Provider Category:Individual **Provider Type:**

Physical Therapist

Provider Qualifications**License (specify):**

NJAC 13:39A-2.1

Certificate (specify):**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

Department of Human Services, Division of Developmental Disabilities

Frequency of Verification:

Initially and at time of license renewal and insurance renewal.

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

Service Type: Other Service
Service Name: Assistive Technology Devices

Provider Category:Agency **Provider Type:**

State of New Jersey Vendor

Provider Qualifications**License (specify):****Certificate (specify):**

Other Standard (*specify*):

Contract with the State of New Jersey and Liability Insurance

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

Department of Human Services (DHS), Division of Developmental Disabilities (DDD), Office of Housing and Resource Development

Frequency of Verification:

Annually

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Assistive Technology Devices****Provider Category:**Individual **Provider Type:**

Occupational Therapist

Provider Qualifications**License** (*specify*):

NJAC 13:44K-2,3,4 & 11

Certificate (*specify*):**Other Standard** (*specify*):**Verification of Provider Qualifications****Entity Responsible for Verification:**

Department of Human Services, Division of Developmental Disabilities

Frequency of Verification:

Initially and at time of license renewal and insurance renewal

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Assistive Technology Devices****Provider Category:**Agency **Provider Type:**

Other Business Entity

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

License, certification, registration, or authorization from the New Jersey Department of Consumer Affairs (NJDCA) or any other endorsing entity and Liability Insurance.

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

Department of Human Services (DHS), Division of Developmental Disabilities (DDD), Office of Housing and Resource Development

Frequency of Verification:

Annually

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

Service Type: Other Service
Service Name: Assistive Technology Devices

Provider Category:Agency **Provider Type:**

Medicaid Provider

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Contract with the State of New Jersey, Division of Medical Assistance and Health Services and Liability Insurance

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

Department of Human Services (DHS), Division of Developmental Disabilities (DDD), Office of Housing and Resource Development

Frequency of Verification:

Annually

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

Service Type: Other Service
Service Name: Assistive Technology Devices

Provider Category:Individual **Provider Type:**

Speech/Language Pathologist

Provider Qualifications**License (specify):**

NJAC 13:44C-1 et seq.

Certificate (specify):**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

Department of Human Services, Division of Developmental Disabilities

Frequency of Verification:

Initially and at time of license renewal and insurance renewal.

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 and Vehicle Adaptations

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 home, appliances (e.g. specialized adaptations to a microwave, feeding spoon or bowl) and/or vehicle, required by the individual’s Service Plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and community, and with out which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual.

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

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 individual, such as carpeting, roof repair, central air conditioning, etc.

Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

Note that this service in combination with Assistive Technology Devices cannot exceed \$11,000.00 every three years. Exceptions may be authorized for issues of health and safety.

An \$11,000.00 limit is set on adaptations both Environmental/Vehicle and Assistive Technology Devices to accommodate an individual upon discharge from an institutional setting into the community during the first year.

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 contractors
Agency	Contracted Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental and Vehicle Adaptations

Provider Category:

Individual

Provider Type:

Individual contractors

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Compliance with State/local building and State motor vehicle codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Developmental Disabilities

Frequency of Verification:

At point of hire.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Environmental and Vehicle Adaptations****Provider Category:**Agency **Provider Type:**

Contracted Agencies

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Compliance with State/local building and State motor vehicle codes.

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

Division of Developmental Disabilities

Frequency of Verification:

At point of hire.

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):

PERS 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. The response center is staffed by trained professionals.

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

PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, 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
Agency	Contracted Agencies
Individual	Individual Contractor

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Personal Emergency Response System (PERS)****Provider Category:**Agency **Provider Type:**

Contracted Agencies

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

UL/ETL Approved Devices

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

Division of Developmental Disabilities

Frequency of Verification:

Annually

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:**

Individual Contractor

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

UL/ETL Approved Devices

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

Division of Developmental Disabilities

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:

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):

Transportation Services allow individuals access to other waiver supports in the community at large. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them.

Transportation Services are only provided as independent waiver services when transportation is not included in the rate charged for the related waiver service. The need for transportation services must be related to enabling an individual to access specific waiver services and fulfill outcomes. The need for these services must be documented in the individual's Service Plan.

Transportation services in this category include drivers, taxi fares, train and bus tickets, or transportation services such as Access Link, or other private contractors. The selected service chosen must be the most cost effective means of transportation that the individual is able to access. Reimbursement for mileage will not exceed the rate established by the State.

Self-Hire - The individual is employed directly by DDD individual and family. The employee uses their personal vehicle.

Agency Hire – The DDD individual and family contract with an agency to provide staffing. The employee uses their personal vehicle.

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

Medicaid payment for transportation under the approved waiver plan is not available through medical transportation, transportation available through the State plan, transportation that is available at no charge, or as part of administrative expenditures.

Additional transportation supports will not be available to residential or day support providers contracted to provide transportation to and from the person's residence to the site(s) of a day program when payment for transportation is included in the established rate paid to the community living or day support provider.

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	Contracted Agency
Individual	Self-Hire

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

Service Type: Other Service

Service Name: Transportation

Provider Category:

Agency ▾

Provider Type:

Contracted Agency

Provider Qualifications**License (specify):**

Valid Driver's License

Certificate (specify):

Valid Vehicle Registration

Other Standard (specify):

Valid Vehicle Insurance

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

Division of Developmental Disabilities

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:

Self-Hire

Provider Qualifications**License (specify):**

Valid Driver's License

Certificate (specify):

Valid Vehicle Registration

Other Standard (specify):

Valid Vehicle Insurance

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

Division of Developmental Disabilities

Frequency of Verification:

Annually

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:

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):

Per N.J.A.C. 10:48A Background checks shall be conducted for those employees of agencies under contract with the Division, working in such contracted programs, who have direct contact with the persons served by the agency. Such employees include, but are not limited to consultants, interns and seasonal employees.

(a) N.J.S.A. 30:6D-63 to 72 requires that the Department shall not contract with any community agency for the provision of services unless it has first been determined that no criminal history record information exists on file in the Federal Bureau of Investigation Identification Division, or in the State Bureau of Identification in the Division of State Police, which would disqualify the community agency head or the community agency employee from such employment.

(b) Fingerprints shall be taken electronically through a "live scan" process. The agency staff shall be responsible to call a toll free number to schedule an appointment to have fingerprints taken. The State Bureau of Identification will check its own records and forward an inquiry to the Federal Bureau of investigation.

(c) It shall be the responsibility of the community agency head to assure compliance with this chapter.

(d) If the criminal history record indicates a conviction for certain criminal or disorderly person's offenses, the employee shall be terminated from employment unless he or she affirmatively demonstrates to the community agency head or the community agency board, if the individual is the community agency head, clear and convincing evidence of his or her rehabilitation.

(e) If a prospective employee refuses to consent to or cooperate in securing a background check, the person shall not be considered for employment.

(f) If a current employee refuses to consent to or cooperate in securing fingerprints for the purpose of a background check, the person shall be immediately removed from his or her position and the person's employment shall be terminated.

(g) A background check shall be conducted at least once every two years.

(h) The community agency head and all employees, who may come in contact with persons served by the agency, shall submit their fingerprints upon employment to the Department of Human Services office as directed by the Division.

(i) If the background check of the community agency head reveals a criminal record as identified below, the community agency board shall determine within 15 working days, if the community agency head has been rehabilitated in accordance with N.J.A.C. 10:48A-3.4.

(j) The community agency head shall ensure that each employee who may come in contact with persons served by the agency shall be fingerprinted in accordance with the procedures contained in this chapter.

(k) All employees shall sign a written consent to the criminal background check (refer to chapter Appendix A, incorporated herein by reference) prior to the time the fingerprints are taken. This consent shall remain on file in the agency.

(l) Individuals shall be disqualified for employment for any of the following crimes or disorderly persons offenses in New Jersey:

(1) Any crime or disorderly person offense involving danger to the person as set forth in N.J.S.A. 2C:11-1 et seq. through 2C:15-1 et seq.

(2) Any crime against children or incompetents as set forth in N.J.S.A. 2C:24-1 et seq.

(3) A crime or offense involving the manufacture, transportation, sale, possession or habitual use of a controlled dangerous substance as defined in N.J.S.A. 24:21-1 et seq.; or

(4) In any other state or jurisdiction, conduct which, if committed in New Jersey, would constitute any of the crimes or disorderly person's offenses described in (l) 1 through 3 above.

Note that additional standards for providers of Respite and Individual Support Services require a criminal background check. The Division through a series of sample reviews ensures that this is being accomplished.

- 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):

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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
Community Care Residence
Group Home
Supervised Apartment

- 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.

Bedroom and private living areas are individualized. Bedtime and wake up time are at the desire of the individual. Food items are purchased based upon the likes and dislikes of the individual residents. The individual maintains a personal needs account and makes purchases based on personal preference.

Community activities are planned in accordance with individual preferences as indicated in the Service Plan. In addition, community activities may be scheduled via resident meetings where the individuals indicate their personal likes and dislikes. Individuals who do not wish to attend a “group” activity do not have to do so.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Community Care Residence

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Transportation	<input type="checkbox"/>
Respite	<input checked="" type="checkbox"/>

Community Transition Services	<input type="checkbox"/>
Case Management	<input type="checkbox"/>
Day Habilitation	<input type="checkbox"/>
Individual Supports	<input checked="" type="checkbox"/>
Environmental and Vehicle Adaptations	<input type="checkbox"/>
Assistive Technology Devices	<input type="checkbox"/>
Support Coordination	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Personal Emergency Response System (PERS)	<input type="checkbox"/>

Facility Capacity Limit:

4

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 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:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Group Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
----------------	----------------------

Transportation	<input type="checkbox"/>
Respite	<input checked="" type="checkbox"/>
Community Transition Services	<input type="checkbox"/>
Case Management	<input type="checkbox"/>
Day Habilitation	<input type="checkbox"/>
Individual Supports	<input checked="" type="checkbox"/>
Environmental and Vehicle Adaptations	<input type="checkbox"/>
Assistive Technology Devices	<input type="checkbox"/>
Support Coordination	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Personal Emergency Response System (PERS)	<input type="checkbox"/>

Facility Capacity Limit:

12

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 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:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Supervised Apartment

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Transportation	<input type="checkbox"/>
Respite	<input checked="" type="checkbox"/>
Community Transition Services	<input type="checkbox"/>
Case Management	<input type="checkbox"/>
Day Habilitation	<input type="checkbox"/>
Individual Supports	<input checked="" type="checkbox"/>
Environmental and Vehicle Adaptations	<input type="checkbox"/>
Assistive Technology Devices	<input type="checkbox"/>
Support Coordination	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Personal Emergency Response System (PERS)	<input type="checkbox"/>

Facility Capacity Limit:

3

Scope of Facility Sandarnds. 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 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:

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.*

Payment will not be made for services furnished by the individual's parent (or stepparent), spouse, or by a guardian, legally responsible relative or relative residing in the service recipient's residence except in the following instance. For no more than 30 days on an annual basis a relative (other than the legally responsible relative) residing in the individual's home may provide Individual Support Services at no more than 40 hours/week, during transitioning/hiring of new staff. The Support Coordinator will verify that Individual Support Services staff have left employment and there is a need for this service as other staff are not available to fill the need. In addition, the individual and/or an individual involved in the self direction process other than the family member rendering the service must verify the service was rendered.

Respite providers who are approved by the DDD may be members of the individual's family with the following qualifying statement. Payment will not be made for services furnished by the individual's parent (or stepparent), spouse, or by a guardian, legally responsible relative or relative residing in the service recipient's residence. The individual and/or an individual involved in the self direction process other than the family member rendering the service must verify the service was rendered.

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

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

- Other policy.**

Specify:

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

With regard to Habilitation Services, provider agencies interested in rendering this service contact the operating agency's Regional Program Staff to determine the requirements (standards) and the need for additional habilitation services in the area in which they wish to render services. Habilitation staff and contract staff work with the provider agency to develop programs that meet waiver standards as individual needs and preferences indicate that additional sites/providers are necessary. Habilitation services provided in the non

traditional style/setting added in 2003 at the waiver renewal may apply to qualify as a service provider. Providers who meet the standard for respite are maintained in a database and individuals are referred as the need presents itself. Authorized providers are developed through the Regional Program staff. Individuals who wish to render this service attend the Community Care Residence Provider Training and pass all requirements with the exception of licensure of his/her home. These individuals provide services in the environment selected and approved by the individual and/or his/her primary caregiver. Environmental and vehicle adaptations contracts are awarded as part of the state three (3) bid process on a case by case basis. All contractors who qualify may bid. (PERS) services are available from local vendors of this service. Individuals/agencies that wish to provide Self Directed services and/or non traditional services may qualify to render the service through the Division's qualification process on an ongoing basis.

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:

State verifies on a periodic basis, that providers meet required licensing and/or certification standards and adhere to other state standards.

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

Agency and provider records, physical layout of residential placements, staff interviews.

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 checked="" 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 type="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS, OPIA, DDL	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: DDL reviews 100% of the providers annually.
	<input type="checkbox"/> Other	

	Specify: <input style="width: 100%;" type="text"/>	
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Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Agency and Provider Records.

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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input 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 type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS, DDD	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: The Regional Monitor will review 24 cases on a random basis in a region each month rotating regions so that each region is reviewed 3 times within the year.
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Unusual Incident Reports (UIR); Follow up Reports, Agency and Provider Records. Any additional records and interview sources.

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 checked="" 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 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 style="width: 100%;" type="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS, OPIA, SRU	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: As appropriate during the course of an investigation.
	<input checked="" type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

	As Needed	
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Data Source (Select one):
 Other
 If 'Other' is selected, specify:
 Qualified Provider List (Family Support Website)

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 checked="" 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 style="width:100%;" type="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS, DDD	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width:100%;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width:100%;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width:100%;" 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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHS, DDD;DHS, OPIA, CIMU;	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: As needed; At the time of initial application.

Performance Measure:

State identifies and rectifies situations where providers do not meet requirements.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Agency and provider records, physical layout of residential placements, staff interviews.

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 checked="" 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 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: DHS,OPIA,DDL	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: DDL reviews 100% of providers yearly. Residences licensed under NJAC 10:44 A&C are reviewed as:10% sample based on the highest level of service need. If issues are id the sample will increase to 25%.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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

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 type="checkbox"/> Operating Agency	<input checked="" 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: DHS,DDD	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: : The Regional Monitor will review 24 cases on a random basis in a region each month rotating regions so that each region is reviewed 3 times within the year.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Unusual Incident Reports, Follow up Reports, Agency and Provider Records. Any additional records and interview sources.

Responsible Party for data	Frequency of data	Sampling Approach (check each
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collection/generation (check each that applies):	collection/generation (check each that applies):	that applies):
<input checked="" 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: DHS,OPIA,SRU	<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 Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Formal SRU letter titled Summary of Findings titled, re: Completion of Investigation to provider, agency and OOL, DDD Regional Administrator and guardian if applicable

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 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: DHS,OPIA,SRU	<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 Source (Select one):

Other

If 'Other' is selected, specify:

Qualified Provider List (Family Support Website)

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 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: DHS,DDD,OQI	<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 Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Referrals, UIRs, UIR follow-up reports, case management notes, OOL reports

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input 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="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS,Early Alert Committee	<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 checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHS,OPIA,DDL; DHS,DDD;DHS,OPIA,SRU & CIMU;DHS,DDD,OQI; DHS,Early Alert Committee	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

<input checked="" type="checkbox"/> Other Specify: As necessary.

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:

State monitors non-licensed/non-certified providers to assure adherence to waiver requirements

Data Source (Select one):

Record reviews, on-site
 If 'Other' is selected, specify:
 Agency and Provider Records

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 type="checkbox"/> Operating Agency	<input checked="" 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: DHS, DDD	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: The Regional Monitor will review 24 cases on a random basis in a region each month rotating regions so that each region is reviewed 3 times within the year.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Record reviews, on-site
 If 'Other' is selected, specify:
 Unusual Incident Reports, Follow up Reports, Agency and Provider Records. Any additional records and interview sources.

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 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: DHS, SRU	<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 Source (Select one):

Other

If 'Other' is selected, specify:

Q-Shared Drive, Day Program Folder, "Reviews Data Set" Excel Spreadsheet

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 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: DHS, DDD, Office of Quality Improvement (OQI)	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: DDD OQI will review 20% of the day habilitation and supported employment (SE) providers annually by random selection. At the end of 5 years all habilitation and SE providers will have been reviewed.
	<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 checked="" type="checkbox"/> Monthly

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHS, DDD, OQI	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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:

State implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved waiver.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Lead training agencies on a monthly basis submit documents re: registration, attendance, cancellations, failures and “no-shows”.

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 checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" 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: DHS, DDD	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Less than 100% review for CCR providers under the auspices of NJAC 10:44B
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Staff Training Records

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 checked="" 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 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: DHS, OPIA, DDL	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: DDL reviews 100% of providers yearly. Residences licensed under 10:44 A&C are reviewed as:10% sample based on the highest level of service need. If issues are id the sample will increase to 25%.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Unusual Incident Reports, Follow up Reports, Agency and Provider Records. Any additional records and interviews.

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 checked="" 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 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: DHS,OPIA,SRU	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Reviewed as necessary during the course of an investigation.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Provider Agency Policy/procedure re. Danielle's Law training. Letter from Provider Agency verifying training.

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 checked="" 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: DHS,DDD,OQI	<input checked="" 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 (<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 checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHS, DDD, DDL; DHS,OPIA,SRU; DHS,DDD,OQI	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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.
NJ Plan for Compliance is as follows:

- Develop reports and follow up actions to DDD waiver monitor audits and the Office of Quality Improvement's reviews.

a. By October 1, 2008 DDD will have developed an electronic platform to allow the Community Care Waiver Monitor to document a review of 268 cases annually. This documentation will note whether or not the provider of service meets the waiver standard.

b. By January 1, 2009 DDD will have developed, at a minimum, quarterly reports that aggregate data by region and identify follow up actions to ensure compliance.

c. By October 1, 2008, DDD will have developed an electronic platform to store, analyze, and trend Day Program Review

information.

d. By January 1, 2009, DDD will have developed the process to distribute Day Program information to the regions. A component of the process will be a strategy to document and report issues and monitor remedial action follow up.

- Develop a comprehensive tracking database to maintain a current provider resource by type of provider, license and certification status, and training programs and updates. Develop reports from aggregated data to determine issues for remediation and remediation status reports.

This recommendation will require a number of complex actions and therefore will take substantial effort and time. A database tracking licensure/certification status exists within the OPIA.

a. By January 1, 2009 DDD will have communicated the need to all providers for the assembling of all provider staff information on a master database maintained statewide including hire dates, dates of required trainings, dates trainings were passed.

b. By January 1, 2010 DDD will begin to examine/evaluate various database platforms and the infrastructure required for providers to directly enter the data indicated into an electronic database. The system selected will allow for the production of reports.

c. By January 1, 2011

i. DDD will have built the electronic data system and initiated a six month schedule of Provider data entry.

ii. STAC will have developed an oversight process to review information and make recommendations, monitor and report on remedial actions.

d. By July 1, 2011 DDD will begin producing quarterly reports for the Statewide Training Advisory Committee to analyze and make recommendations regarding remediation.

e. By October 1, 2011 the Statewide Training Advisory Committee will initiate the oversight process listed in c. ii..

- Develop regional and/or statewide training databases to track all personnel and providers for training program compliance. Develop reports from aggregated data to determine issues for remediation and remediation status reports.

The plan of remediation for the recommendation immediately preceding this recommendation will also address this.

- Provide a direct link for the Family Support Qualified Provider database on the DDD home page. Maintain a database offline of the community qualifications and agreements with the "Other Agencies" category of habilitation resources (examples of "Other Agencies" are fitness programs, senior centers, etc.).

A direct link for the Family Support Qualified provider database on the DDD home page exists. You can locate it on the home page (right hand side) under NJ Family Care in the "I want to" section "find out about Real Life Choices database". Clicking there takes you directly to the Family Support Qualified Provider database. The rest of the recommendation that DDD maintain a database offline of the community qualifications and agreements with the "Other Agencies" is not possible electronically due to the fact that electronic signatures have not been refined enough to allow us to do this for every new applicant. However, a hard copy (paper) file is maintained in the Division's Central Office.

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.

NJ initially inspects/authorizes agencies to render services through a licensing or review process. If issues are identified at this stage the provider must take corrective action before being licensed or authorized to render services.

During the course of rendering services providers receive ongoing oversight through annual licensure, site visits from case managers (monthly or quarterly), reviews by the DDD Office of Quality Improvement (OQI) and/or DDD regional training liaisons.

Case Mangers identify issues in progress notes and require follow up to address the issue incorporating appropriate levels of assistance (e.g. DDL, DDD Regional Administrators, DDD Contract Administrators, etc.) to ensure cooperation.

Issues identified by DDL of import may require a plan of correction and/or suspension of licensure or termination of licensure. Numerous DDD Circulars and Regulations require the reporting of Abuse, Neglect and Exploitation. Investigations of all contracted providers are done by the DHS, OPIA, and Special Response Unit (SRU). Investigative results are forwarded to DDD and DDL for appropriate action to ensure resolution.

Abuse, neglect and exploitation allegations, investigations and outcomes are tracked on the Unusual Incident Reporting Management System (UIRMS) by the DHS, OPIA, and Critical Management Unit (CMU).

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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHS, OPIA, CIMU	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: As necessary.

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 Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

This information is provided in Appendix B-2: Individual Cost Limit, section b: Method of Implementation of Cost Limit. DDD has developed an assessment tool which determines an individual's ability to function at an independent level. The tool assigns a support level for individuals with similar abilities and needs. The tool is applied after the individual is deemed eligible for the waiver. A base amount is set which is augmented by issues requiring additional or intensive services such as behavioral and/or medical needs. The budget levels were calculated against service costs necessary to ameliorate the concerns.

The tool allows for an additional \$10,000.00 for a six month period to address temporary circumstances that may require additional services. If the life change is permanent the individual can be reassessed and assigned to a higher level of need with a commiserate increase in budget.

NJ proposes to utilize this method of assessment for all individuals who self direct, enter waiver services after the amendment is approved, as well as those who experience significant changes in service needs. Please note that NJ has a grid document that can be furnished upon request delineating each level and the amount associated with that level.

As this amendment application will only be effective for one year there is no need to adjust the set budget limits.

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

Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Essential Life Style Plan – ELP (Self Directed Services and Provider Managed Services for those with an individual budget),

- 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:

QMRP as defined in 42 CFR 483.430

- Social Worker.**

Specify qualifications:

- Other**

Specify the individuals and their qualifications:

The Regional Monitor is a State employee who meets the standard for case management and whose qualifications are equivalent to the QMRP.

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:*

The Case Manager is responsible to advocate on behalf of the waiver participant's requests, attempting to mitigate risks as

necessary per Division Circular #35. This responsibility includes ensuring that the individual receives full disclosure regarding the participant's right to freedom of choice of providers, the full range of waiver services available, and the individual's option to choose a different entity or person to develop the plan. In addition, the individual's guardian (for individuals adjudicated incompetent) would also be advised of these rights. The case manager has the responsibility for conducting the meeting, coordinating the services, finalizing and authorizing the service plan.

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.

Provider Directed Services

For individuals living in their own home (OH) and attending a waiver day habilitation service the participants are encouraged to self-direct the Service Plan (SP) meeting as much as possible.

Prior to the SP meeting staff who work directly with the individual will complete assessments, as applicable. At minimum, the Division of Developmental Disabilities will ensure that an Adaptive Behavior Summary (ABS) is completed for each waiver participant. The ABS includes the following domains; a) self-help skills, b) communication skills, c) social skills, d) communication awareness and e) physical conditions, limitations and assistive devices which allows the Division of Developmental Disabilities to collect information regarding the participants strengths, capacities, preferences, needs and desired outcomes.

Prior to the meeting the service provider is responsible for gathering information regarding the participant's preferred outcomes. Assessments and the SP tool are public documents available to IDT members for completion and/or review prior to the SP meeting. The waiver participants have the authority to determine who is included in the SP process and meeting, but will include at a minimum the Case Manager, service provider and guardian. The Case Manager is responsible to advocate on behalf of the waiver participant's requests, attempting to mitigate risks as necessary per Division Circular #35. This responsibility includes ensuring that the individual receives full disclosure regarding the participant's right to freedom of choice of providers, the full range of waiver services available, and the individual's option to choose a different entity or person to develop the plan. In addition, the individual's guardian (for individuals adjudicated incompetent) would also be advised of these rights. The case manager has the responsibility for conducting the meeting, coordinating the services, finalizing and authorizing the service plan.

Self-Directed

For individuals who are self-directing their supports and services, the Support Coordinator (SC) and Regional Monitors (RM) are responsible for assisting participants and/or family members to create outcomes through their Essential Life Plan (ELP) which utilizes a person-centered philosophy. The participant is encouraged, by the SC, to invite individuals of his/her choosing to participate in the ELP development. The SC is responsible for providing information about the range of services and supports offered through the waiver in advance and during the ELP meeting. The SC facilitates the ELP process by assisting families in the development of the plan, empowering them to remain in control of the plan, and creating plan outcomes.

NJ has contracted with the Elizabeth M. Boggs Center on Developmental Disabilities to offer training opportunities on the ELP and to conduct a "Train the Trainers" to aid in fostering service recipient's participation at all levels of planning. Currently there is an ELP 1 and an ELP 2 training option. ELP 1 is a full two day training on the person-centered philosophy of the ELP. ELP 2 is a full three day training focusing on the practical application and development of the ELP. ELP 1 and 2 training options are mandatory for all Support Coordination agencies and are also available to all members of the community.

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):

Provider Directed Services

For individuals living in their own home (OH) and attending a waiver day habilitation program it is the responsibility of the provider agency to coordinate the individual's Service Plan (SP) meeting. The provider agency, or delegate as identified by the waiver participant, invites the members of the Interdisciplinary Team (IDT) to the annual SP meeting. The IDT members typically consist of the waiver participant, guardian, family members, provider agency staff and the Case Manager. The IDT may be smaller or larger depending on the preferences of the waiver participant.

Prior to the SP meeting the provider will complete assessments, as applicable. At minimum, the Division of Developmental Disabilities will ensure that an Adaptive Behavior Summary (ABS) is completed for each waiver participant. The ABS includes the following domains; a) self-help skills, b) communication skills, c) social skills, d) communication awareness and e) physical conditions, limitations and assistive devices which allows the Division of Developmental Disabilities to collect information regarding the participants strengths, capacities, preferences, needs and desired outcomes.

At the SP meeting the outcomes of the ABS and any other assessments that were completed (e.g.: self-medication assessment) are reviewed and discussed. The SP utilized by the Division of Developmental Disabilities also ensures that the following topics are discussed: a) life plan summary which identifies the preferred outcomes of the waiver participant, b) relationships which addresses the people who are important to the participant and the support needs in maintaining and establishing new relationships, c) residential preferences and needs, d) work/program/school preferences and needs, e) community and recreation preferences and needs f) physical and emotional well being supports needed, g) clinical information including medications and professionals seen, h) medication administration preferences and needs, I) guardianship status, preferences and needs, j) financial review including status, preferences and supports needed, k) supervision preferences and needs, l) transportation preferences and supports needed, and m) goal identification which takes into consideration the participants desired outcomes while balancing the risks and/or needs. It is the Case Manager's responsibility to ensure that all of the above are discussed thoroughly and that all members of the IDT are actively engaged in plan development, that the participant is informed of the full range of waiver services available under the waiver, his or her right to freedom of choice of providers, and that the service plan addresses the participant's goals, needs and preferences. In addition, the individual's guardian (for individuals adjudicated incompetent) would also be advised of these rights. The case manager has the responsibility for conducting the meeting, coordinating the services, finalizing and authorizing the service plan.

The Division of Developmental Disabilities ensures that the plan development process results in the assignment of responsibilities by including in the SP, under each domain, the action required (if necessary) and the entity responsible for implementation.

Following the SP meeting, it is the responsibility of the provider to finalize the written plan developed at the meeting and submit the plan to the Case Manager, in printed or electronic format, in accordance with the time lines outlined in Division Circular #35 (DC#35). The Case Manager is responsible to ensure that the plan content reflects the SP meeting discussions, the identified outcomes include scope, frequency and duration, the re-evaluation of the level of care and assessments are completed, and all other pertinent information as identified in DC#35 is included. The Case Manager then approves the SP and ensures that IDT members receive a copy of the approved plan.

It is the responsibility of the provider to update assessments any time there is a change or anticipated change in the individual's health, welfare or safety. An IDT meeting will then be held to modify the SP. The service provider modifies the plan based on the information presented and decisions made during the IDT meeting. The modification approval process is the same as the initial plan approval process. The Case Manager is responsible to enter the date of the initial plan and any modifications into an electronic database. NJ is in the process of developing an alert system which will help facilitate the current system of ensuring the timeliness of Service Plans.

Self-Directed

For individuals who are self-directing services through a budget the Essential Lifestyle Planning (ELP) document is used as the SP. Individuals who are receiving services through the assessment of a level of need identified in this document may also use the ELP. The ELP is a nationally recognized life planning tool, linking like needs directly to like supports and service. The services requested and provided must be very individualized. The ELP starts with what the participant wants to live a full life (important to) and balances that with any health and safety issues (important for). It is a guided process for assisting the participant to live a complete life and develop a plan to make it happen.

The ELP, is an interactive process that includes conversations covering topics including: a) hopes and dreams, b) identifies who helped develop the plan, c) great things about the person, d) what/who is important to the person (preferences), d) what is important for the person (health, welfare and safety support needs), f) things to still figure out, g) communication style and meanings, h) the participants and family perspective (the upside), regarding what is working in their life, I) the participant and family perspective (the downside), regarding what is not working in the participants life, j) the to do list (goals, action planning including who is responsible) and k) the outcomes. The outcomes identify the specific waiver service to be received, the frequency, scope and duration.

Support coordination is a facilitative process that assists individuals and families in remaining in control of the plan. Support Coordinators work face-to-face with the individuals and their families throughout the entire process. While Support Coordinators are the primary contact with the individual and his/her family, they are part of a team, which includes the Regional Monitor (e.g.: State QMRP) that is responsible for the development and implementation of the ELP. The initial step of NJ's Self-Direction is for the State Regional Monitor (RM) and the SC to meet with the waiver participant and his/her family for an orientation to NJ's Self-Direction utilizing a budget (the ELP assessments, tool, and worksheets are provided at the orientation).

Following the Orientation (referenced in c. above) the individual or their family returns the partially completed ELP documents to the SC and then the SC and the individual and family member review the "draft" plan and add additional information as necessary. The Things Others Need to Know to Help Your Family Member Stay Healthy and Safe (Health and Safety Checklist) an assessment to

address health, welfare and safety needs is also reviewed at this time.

Approximately 30 days after the orientation, the ELP meeting is held and the entire team is invited to the meeting. The individual and/or family are responsible to identify the team members. Team members typically include the individual, the family, the SC, the RM, and other involved persons; however the specific number of the team members is dependent upon the individual's preference. The "draft plan" is reviewed at this meeting, outcomes are verified or further developed, and decisions about services needed are put into place.

It is the support coordinators responsibility to ensure the documentation of and coordination of waiver, state plan and other services. The Support Coordinator will also direct the individual and family to the Division of Developmental Disabilities endorsed Family Support Center website which includes a list of all qualified providers of waiver services. The ELP further ensures that risks are identified and addressed, including responsibilities and measures for reducing the risks and health care needs through the "what's important to the person vs. what's important for the person" section of the ELP. The Support Coordinator and Regional Monitor ensure that each individual has developed a back up plan to address unexpected circumstances that may arise during the course of the year and to embed that back up plan in the ELP.

The SC must electronically upload the completed ELP on the secure website. The state employee, RM, (QMRP) then reviews the plan for completeness and approves the ELP.

Services are self-directed through a participant-directed budget. A Resource Tool has been developed which assesses individual's competencies and determines relative need for service. by assessing the skills of individuals with developmental disabilities in the areas of cognition, self-care and mobility. There are currently seven (7) levels of need identified. Once a level of need is determined, this information is used to develop an individualized budget range with a set "up to" amount. There is a strong correlation between the competencies of the individual and the amount and duration of support services needed. The assessment and individualized budget builds equity into the system to ensure that individuals with like needs receive like resources.

DDD utilizes a fiscal intermediary to pay for the identified services/supports of self directed individuals.

The Regional Monitor approves all expenditures and notifies parties on an ongoing basis if the budget is being overspent. The Support Coordinator assists the family is budgeting and ensuring that they do not over spend the budget.

Note that the SP utilized (i.e. IHP, ELP) will identify state plan and generic community supports that will help the individual attain his/her desired outcomes. Waiver services will be included that will complete the total service package to address the individual's needs and desired outcomes.

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.

The Case Manager/Regional Monitor and contracted agency plan coordinator are responsible during the time of annual service plan development to complete an Adaptive Behavior Summary tool. This tool identifies potential risks. Through the Interdisciplinary Team process identified potential risks and the supports needed to mitigate them are addressed in the individual's service plan.

Assessments and needed supports in the Annual Service Plan are categorized as follows: Biography, Life Plan Summary, Relationships, Residential, Work/Program/School, Community and Recreation, Physical and Emotional Well Being, and Clinical, which is divided into subcategories of; Significant Diagnoses, Medications, Medication Administration, and Professionals Seen. Additional categories are Guardianship, Financial, Supervision Transportation, Additional Supports Services, and Additional Important Information. For each of the above listed categories the following is documented in the service plan: the Meeting Discussion, Actions Required and Person Responsible. Additionally the Medication Administration, Guardianship, Financial, Supervision, Transportation, and Additional Support Services categories, contain sub-questions that provide for detail specific needs and supports.

The "Rational for Goal Identification" section requires an assurance statement that the annual goals address, and are derived from, health and safety concerns and the aspirations of the individual.

Case Managers/Regional Monitors will approve the SP only after a thorough review of the assessed needs, preferences (including choice of provider) and risks thus ensuring that the document satisfactorily addresses the required elements.

The Case Manager/Regional Monitor and the Waiver Monitor will monitor service plan implementation as outlined in section F-2 of this document. Trend analysis of such factors as satisfaction with service delivery and frequency and severity of Unusual Incidents will be utilized to assist in decisions regarding systemic changes and quality initiatives on an annual basis.

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.

The Case Manager/Regional Monitor is responsible to ensure that the participant is informed of the service providers available and that the selection of providers is unbiased. At an SP or IDT meeting, the uniqueness of each provider (e.g.: geographic location of the provider, hours of operation) is discussed to help the participant make an informed choice. The participant may also be encouraged to visit and/or try out the services of more than one provider in order to make an informed choice regarding service selection. The service plan asks individuals to make any request for change in providers known and the Case Manager, Support Coordinator and/or Regional Monitor assist the individual in actualizing any changes requested.

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 designee for the Single State Agency, the Division of Medical Assistance and Health Services (DMAHS) will review and approve the Service Plan form templates. By an ongoing review of all Fair Hearing Appeals, DMAHS will determine if the Service Plan meets the needs of the individual.

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:

The DDD Regional Monitor has access to the ELP electronic record and maintains a hard copy of the ELP in the individual's file in the regional office.

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.

Provider Directed

(a) Service Plan monitoring for contracted licensed provider agencies, is conducted by Case Managers and a Waiver Monitor.

(b) Case Managers operate out of four regions in the state and the Waiver Monitor operates out of Central Office. Case Managers review and approve the Individual Service Plans for persons on their case load, record the data of approval and enter the Plan into the DDD database. The Waiver Monitor audits a sample of records from each region and generates reports for Quality Improvement efforts.

A Case Manager is responsible to visit each individual residing in contracted agency residences on a quarterly basis and those individuals residing in community care residences on a monthly basis. With regard to agencies, the Case Manager will review the implementation of the SP and the health and welfare of 50% of the individuals in each program at the quarterly visit. With regard to community care residence 100% of the individuals will be reviewed. The areas that are reviewed include, but are not limited to: a) date of the SP, b) date the SP outcomes were implemented, c) services to determine if they are furnished in accordance with the SP, d) barriers to SP implementation to determine if they are noted and result in timely SP modifications, e) services to determine if they meet the needs of the individual, f) any changes or anticipated changes in the participant's health, welfare and safety to determine if a timely re-assessments and SP modifications occurred, g) outcomes include scope, duration and frequency, h) medication monitoring, i) action plans (to determine if they are identified when needed, j) review of finances. The Case Manager, when conducting the face-to-face direct contact with the individual will inquire about their satisfaction with services and those agencies or individuals providing them.

In addition to the monitoring by the Case Manager, the Waiver Monitor conducts audits of a random sample of participants in the Community Care Waiver. The monitoring instrument is designed to determine if documentation in client files reflect timely completion of the Level of Care determination (certification/recertification) process, proper execution of Freedom of Choice (Choice of Location) statements, timely preparation and implementation of Service Plans, and if required Case Manager/Regional Monitor/Support Coordinator/Peer Mentor observations have been recorded. When documents show that items are missing and/or not completed timely, such items are reported as deficiencies. Deficiencies are reported to Regional Administrators who are required to report the corrective actions taken to address these issues both individually and systemically within 90 calendar days.

Self-Directed

For individuals who are self-directing a budget the Support Coordinator (SC) and the Regional Monitor (RM) monitor the implementation of the ELP (service plan) including the individual's health and welfare. The monitoring and follow-up methods used consist of face-to-face contacts and phone contact by the SC and the RM. At a minimum the contact is quarterly face to face. The monitoring plan depends on the vulnerability of the individual. For individuals who are functioning well and receiving many services in the community from a variety of providers who report on their well-being, the Regional Monitor may be able to review the electronic record of services being delivered and the individual's employment status and can carry out monitoring through telephone discussions with the individual, the caretaker(s), and service providers with less frequent face to face meetings when the individual reports being stable and satisfied for a year and the discussion and agreement is documented in the service plan. Increased face to face contact for individuals who are more vulnerable will also be documented in the Service Plan.

Typically the amount of involvement in the formulation of the ELP is greater than when the ELP services and supports are ongoing however, it is based upon the individual and family need. The SC will assist the individuals and families to locate support and services identified in the ELP. These services may be natural (e.g.: community resources, friends), generic (e.g.: Division of Vocational Rehabilitation (DVR) or another agency not funded by the Division), State Plan or waiver (e.g.: individual supports, habilitation, respite). The SC will visit the individual/family member monthly or quarterly, as needed and document issues/concerns and/or consumer satisfaction with service delivery. The issues reviewed include, but are not limited to: a) do the services continue to meet the needs of the individual, b) are there any changes or anticipated changes in the individuals health, welfare and safety, c) are the outcomes being met, d) are modifications needed, e) are there any barriers to service and if so, how are the barriers being addressed f) is the individual and family satisfied with the service providers and what is the overall plan progress toward achieving the individual outcomes. In addition the SC will review the budget expenditures and availability of remaining budget with the individual and family.

The ELP electronic record allows for reports to be generated regarding the timeliness of the ELP and modifications, the use of the services and supports, the budget that has been spent, etc.

In addition to the monitoring conducted by the SC and the RM, the CCW Monitor will audit a random sample of individuals receiving waiver services. The monitoring instrument to be used is designed to show timely completion of the Level of Care determination (certification/recertification) process, proper execution of Freedom of Choice (Choice of Location) statements, timely preparation and implementation of the ELP and the documentation and approval of completed Waiver Tool. When items are missing and/or not completed in a timely manner, such items are reported as deficiencies. Deficiencies are reported to the Regional Administrators who are required to report the corrective actions taken to address the issues both individually and systemically (when appropriate) within 90 calendar days.

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

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

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

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

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:

Plans of Care address all participants assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

Consumer and provider interviews; Case manager progress notes; Review of progress of current goals; Review of medical evaluations. Provider of service monthly progress reports. Prior IHP.

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 checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" 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="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS,DDD	<input checked="" 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 Source (Select one):

Other

If 'Other' is selected, specify:

Plan of care/IHP document (confirmation of participation and of determination of service need)

Assessment documents as appropriate (e.g. Adaptive Behavior Summary (ABS))

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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" 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: DHS, DDD	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: The Regional Monitor reviews 24 cases in a region on a random basis in a region each month rotating regions so that each region is reviewed 3 times within the year.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Assessment documents as appropriate (e.g. Adaptive Behavior Summary (ABS), IHP, medical records, monthly reports, critical incident log, UIRs, staffing.

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 checked="" 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 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: DHS,DDL,DDD	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: DDL reviews 100% of providers yearly. Residences licensed under 10:44 A&C are reviewed as: 10% sample based on the highest level of service need. If issues are id the sample will increase to

		25%.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

IHP and Unusual Incident Report, Medical Reports, Agency Logs

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 checked="" 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 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: DHS, OPIA, SRU	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Documents are examined based upon information that arises in the course of an investigation.
	<input checked="" type="checkbox"/> Other Specify: As issues arise during an investigation.	

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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHS, DDD, DDL	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: As issues are identified in the course of an investigation and a pattern becomes evident.

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:

Monitor SP development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the development of the SP.

Data Source (Select one):

Other

If 'Other' is selected, specify:

IHP/ELP (confirmation of participation and of determination of service need) Assessment documents as appropriate (e.g. Adaptive Behavior Summary (ABS))

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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" 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: DHS, DDD	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: The Regional Monitor reviews 24 cases on a random basis in a region each month rotating regions so that each region is reviewed 3 times within the year.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

IHP/ELP, medical records, monthly reports, critical incident log, UIRs, staffing.

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 checked="" 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 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	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: DHS, OPIA, DDL		Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 100% of the agencies authorized under NJAC 10:44A & C are reviewed annually.
	<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 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: DHS, OPIA, DDL	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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:

Service Plans are updated/revised when warranted by changes in the waiver participant's needs.

Data Source (Select one):

Other

If 'Other' is selected, specify:

IHP (confirmation of participation and of determination of service need)

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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" 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: DHS, DDD	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: The Regional Monitor reviews 24 cases on a random basis in a region each month rotating regions so that each region is reviewed 3 times within the year.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

IHP, medical records, monthly reports, critical incident log, UIRs, staffing

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 checked="" 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 type="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS, OPIA, DDL	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 100% of the agencies authorized under NJAC 10:44A & C are reviewed annually.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Provider Progress Notes, Interdisciplinary Team (IDT) meeting minutes.

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 checked="" type="checkbox"/> 100% Review
<input 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 type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS,DDD	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Case Management Supervisors will review monthly 5% sampling of plans of care completed within last 30 days and document whether or not all participants' assessed needs, personal goals were addressed.
	<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 checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHS, OPIA, DDL; DHS, DDD	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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:

Services are specified by type, amount, duration, scope, and frequency and are delivered in accordance with the Service Plan.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

IHP (confirmation of participation and of determination of service need.

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 type="checkbox"/> Operating Agency	<input checked="" 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: DHS, DDD	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: The Regional : The Regional Monitor will review 24 cases on a random basis in a region each month rotating regions so that each region is reviewed 3 times within the
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

IHP, medical records, monthly reports, critical incident log, UIRs, staffing

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 checked="" 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 type="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS, OPIA, DDL	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 100% of the agencies authorized under NJAC 10:44A & C are reviewed annually.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

	<input style="width:90%;" type="text"/>	
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Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

IHP and Unusual Incident Report, Medical Reports, Agency Logs

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 checked="" 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 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 style="width:80%;" type="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS, SRU	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width:80%;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: The SRU reviews these files and the status of this assurance if it arises as an issue during the course of the investigation.
	<input checked="" type="checkbox"/> Other Specify: As required upon the completion of an investigation.	

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Proposed goals and objectives, assessment tools as appropriate.

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 checked="" 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 style="width:80%;" type="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS, DDD	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width:80%;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width:80%;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width:80%;" type="text"/>	

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

Monthly provider progress reports, interviews with consumer and service providers

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 checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" 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="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS, DDD	<input checked="" 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 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 checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHS, DDD; DHS, OPIA, DDL; DHS, SRU	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: As the issue identified in the course of an investigation.

- 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:

Participants are afforded choice between waiver services and institutional care, and between/among waiver services and providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Consumer interviews, monthly provider reports, on site visits

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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" 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="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS, DDD	<input checked="" 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 Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

IHP (confirmation of participation and of determination of service need)

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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" 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: DHS,DDD	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Regional Monitor will review 24 cases on a random basis in a region each month rotating regions so that each region is reviewed 3 times within the year.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

	<input style="width:90%; height: 20px;" type="text"/>	
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Data Source (Select one):

Other

If 'Other' is selected, specify:

Q Shared Drive, Day Program Folder, "Reviews Data Set" Excel Spreadsheet

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 checked="" 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 style="width:80%;" type="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS, DDD, OQI	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width:80%;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: OQI reviews a 20% sampling of agencies providing day habilitation and supported employment services on an annual basis.
	<input type="checkbox"/> Other Specify: <input style="width:80%;" type="text"/>	

Data Source (Select one):

Presentation of policies or procedures

If 'Other' is selected, specify:

Your Rights as a Consumer of the Division of Developmental Disabilities (N.J.S.A.30:6D-1-12)

Division #35 is used as a guiding source.

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 checked="" 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 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 style="width:80%;" type="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS, OPIA, DDL	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width:80%;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 100% of the agencies authorized under NJAC 10:44A & C are reviewed annually.
	<input type="checkbox"/> Other Specify: <input style="width:80%;" type="text"/>	

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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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHS, DDD; DHS,DDD,OQI	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

- 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. With regard to the Level of Care assurance NJ is developing an uniform methodology for monthly random sampling and analysis of client reviews for two (2) tiers of oversight at the Case Management Supervisors and Community Care Waiver Monitor levels. The process is projected to be finalized in October of 2008. Quarterly aggregation of trend/analysis reports will begin in January of 2009 when a process will be in place to conduct trend analysis of timeliness and appropriateness of determinations. Remediation will be tracked where issues are identified.

With regard to the assurance that Plans of Care are responsive to Waiver Participant needs. NJ DDD will create a system with a dual tier of oversight . An electronic platform to track two tiers of oversight will be developed by October 1, 2008 to allow the Case Management Supervisors to review monthly a five percent sampling of plans of care. An electronic platform will also be developed to allow the Community Care Waiver Monitor to review 268 cases annually. Quarterly reports aggregating and identifying issue from reviews will be developed by January of 2009.

An electronic alert notification process informing the Case Manager (QMRP) and his/her supervisor of plans of care due within 60 days and those that are overdue by 30 days will also be developed in July 2008.

This system will allow reviews that will encompass all of the subassurances and permit trending analysis and systemic remediation where necessary.

With regard to Assurance III: "Qualified Providers Serve Waiver Participants" NJ will develop by October of 2008 an electronic platform to allow the Community Care Waiver Monitor to document a review of 268 cases annually. By January 2009 DDD will have developed, at a minimum, quarterly reports that aggregate data by region and identify follow up actions to ensure compliance. In addition by October of 2008, NJ will have an electronic platform to store, analyze, and trend Day Program Review information. A process to distribute Day Program information to the regions will be in place by January 2009.

Over the course of the next three years NJ will work on building a database to track all provider staff information on a master database maintained statewide including hire dates, dates of required trainings, dates trainings were passed. The database is projected to be completed by January of 2011. From this database NJ will produce quarterly reports for the Statewide Training Advisory Committee to analyze and make recommendations regarding remediation.

A direct link for the Family Support Qualified provider database on the DDD home page exists. A hard copy (paper) file of qualified provider is maintained in the Division's Central Office.

With regard to the "Health and Welfare of Waiver Participants" assurance NJ developed a risk management system that will aggregate, analyze, and provide summaries of problem remediation to ensure the health and safety of waiver participants. The system includes a Quality Indicators Report that is issued quarterly, and includes the following domains: incident reporting, abuse and neglect investigation, inspection and program review, and fiscal integrity. A Council on Systemic Risk comprised of a cross section of Department managers analyzes the data, determines course of action, and institutes a timeline for completion of action steps. Quarterly review of data by the Council will measure the success of the action plan.

By October 2008 a quarterly report will provide trending information through the aggregation of incidents by region, type,

investigative assignment and findings for all associated Divisions.

By October 2009 a quarterly report will described the information regarding actions taken in response to findings.

Assurance V: requires that “State Medicaid Agency Retains Administrative Authority over the Waiver Program”.

The Quality Management Unit (QMU) of DMAHS (the designee for the Single State Medicaid Agency), will provide ongoing evaluation and documentation of CMS quality assurance measures through a system of annual comprehensive desk audits, interim targeted desk audits, interim targeted on-site audits, topic audits, and participation in the DDD quality assurance meetings and Interagency meetings. In May 2008 the QMU began conducting annual comprehensive desk audits covering the level of care need determinations, the responsiveness of Plans of Care to participant needs, the assurance that individuals receive services from qualified providers, the assurance that health and welfare of waiver participants are addressed, and the assurance that there is appropriate fiscal accountability for payment related to services rendered. Upon completion of any audit, QMU will prepare a written audit report which will be sent to the audited agency within 60 days summarizing general findings, any identified areas requiring remediation as well as agency strengths.

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.

Case Managers who work for the DHS, DDD document monthly or quarterly contact with the individual and address any concerns through the system (e.g. licensing concerns would be reported to DHS, OPIA, DDL, unusual incidents would be reported through UIR procedures to initiate an investigation. If it were a change in needs, a Modified Service Plan would be developed. Referrals for medical issues would be addressed with the service provider.

The Waiver Monitor would document individual concerns and report them to the Regional Administrator for corrective action both individually and systemically within 90 days.

SRU would report findings of an investigation to DDD and DDL for appropriate follow up and action.

The DDL would in the course of licensure and/or in response to investigative findings take action which could include a suspension and/or termination of licensure. A suspension of licensure would require a plan of correction within 30 days.

CIMU would document on the Unusual Incident Report Management System (UIRMS) the findings of investigations.

- 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 checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHS, DDD; DHS, OPIA, DDL & SRU & CIMU	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: As investigative findings are delineated.

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 Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

With regard to the Level of Care assurance NJ is developing an uniform methodology for monthly random sampling and analysis of client reviews for two (2) tiers of oversight at the Case Management Supervisors and Community Care Waiver Monitor levels. The process is projected to be finalized in October of 2008. Quarterly aggregation of trend/analysis reports will begin in January of 2009 when a process will be in place to conduct trend analysis of timeliness and appropriateness of determinations. Remediation will be tracked where issues are identified.

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Assurance V: requires that "State Medicaid Agency Retains Administrative Authority over the Waiver Program".

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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

- 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.

Self-Direction began in 1997 with the Self Determination program. Through a succession of Quality Improvement efforts, the system has evolved.

Budget Authority/Fiscal Management

Participants in Self-Direction have budget authority over the resources allocated to them as well as the ability to hire/fire staff. They can choose to hire qualified individuals to support them (using a Fiscal Intermediary), authorize changes in qualified providers or they can purchase supports from the traditional provider agencies. A contracted Fiscal Intermediary supports participants in managing their budget authority. This Fiscal Intermediary acts as the employer of record for individuals whom the participant chooses to hire and pays individuals and/or agencies for services rendered to the participant.

Method of Budget Determination

New Jersey is utilizing a methodology based on level of support. Individuals are grouped by the level of support needed and given a maximum budget amount based on their grouping. Costs for the typical service set for each group were established using reasonable and customary rates for these services. The budget amount for each group was determined by an analysis of services required to satisfy the individual need for supports and establishing a maximum budget amount. Additional dollars are infused to the base amount for specific needs that may require additional and/or enhanced services (e.g. behavioral issues, medical issues).

New Jersey is utilizing the DDD Individualized Resource Tool. Nationally recognized experts for reliability and validity have evaluated the tool. It assesses individual competencies and determines relative need for services and supports by assessing the individual in the following areas: cognition, communication, self-care and mobility and determines the grouping that would meet the individual's needs. There are seven (7) groups of individuals with similar levels of need determined by the tool. Each grouping is allocated a corresponding budget amount over which the individual has authority.

Level I

Individual needs assistance in community integration skills (e.g., independent use of public transportation).

Level II

Individual needs assistance in shopping, money management and activities of daily living.

Level III

Individual needs assistance in the following areas of daily living; dressing, choosing clothing, meal preparation, and understanding money concepts.

Level VI

Individual needs assistance in getting out of bed, ambulating and in the following daily living activities; dressing, eating, managing money.

Individuals applying for waiver services and their families are invited to an orientation conducted by staff known as Regional Monitors who are QMRPs. The Orientation Meeting presents information on the person-centered planning process known as Essential Lifestyle Planning (ELP). Individuals are given forms to list information about themselves that will help them, their families and other people who care about them describe the "things that are important for the individual" and put into words both the outcomes they want to achieve and the things about the individual that a person providing support will need to know. The ELP tools and process, together with a Health and Safety checklist, assist the individual and the person who know him/her best work with the Support Coordinator and others to develop a Service Plan that identifies the necessary waiver services and supports. The plan will identify state plan, natural community supports (e.g. community resources, friends), and generic community supports (e.g. Division of Vocational Rehabilitation (DVR) or another agency not funded by the Division) that will help the individual attain his/her desired outcomes. The budget is used to purchase waiver services that complete the necessary services comprising the total service package to address the individual's needs and desired outcomes.

The Orientation provides the individual and family with an understanding of the planning process, the responsibilities they will assume in self-direction and the assistance they can expect from the Support Coordinator, Regional Monitor and the Fiscal Intermediary. They are advised regarding how to use the website and other services of the Family Support Center to identify qualified and/or licensed providers in their area.

At the Orientation, individuals who want to request a reassessment of their level of need and corresponding budget amount are given information on how to request the reassessment. They are also given information on the circumstances under which a fair hearing can be requested and how to request one. An orientation packet given to them provides reference material and contact information regarding the Regional Monitor, Support Coordinator, Family Support Center and other resources.

Initially individuals who chose to self direct are assigned a Support Coordinator by the Division's Regional Monitor.

Individuals/families can request a change in support coordinator at any time.

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:

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

Individuals who self direct must demonstrate the capacity and desire to do so and/or must appoint a representative (unpaid) who is willing to self direct for him/her.

With regard to "capacity" a QMRP must confirm that the individual/family has the cognitive capability and would be competent to self direct services and supports.

With regard to "desire", after the orientation, in which individuals and families receive information regarding self-direction, individuals/families have the option to choose to self-direct if they wish to do so.

There is no blanket exclusion of individuals from involvement in self directed services.

Any exclusion from self direction is based on an individual's demonstrated inability to carry out the responsibilities of participant direction. This exclusion is determined by the individual's Interdisciplinary Team and/or their legal guardian if guardianship has been established. For determining capacity the IDT, which is comprised of at least one QMRP, agrees the individual/family has or does not have the cognitive capability to self direct his/her services and supports.

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.

Individuals are invited to an orientation session where they receive an overview of participant –directed services.

They receive a written description of the full initiative as well as their responsibilities if they choose to self-direct. They are informed of the benefits of self-direction as well as the liabilities (lack of an agency in charge of services). The Regional Monitor, an employee of the State of New Jersey, Division of Developmental Disabilities, is responsible for providing this information. This individual is also responsible for explaining the assessment process and the individual budget amounts. All information is provided in an orientation packet distributed at the first orientation session

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 service plan utilized for the self directed process is the Essential Life Style Plan. The assessment of and attention to the needs and desires of the individual service recipient is imbedded in the document. This is reinforced in Division Circular 35 regarding the service plan. This Division Circular is currently in revision with input from stakeholders, to further enhance understanding of the service plan as it relates to both provider directed and self-directed services. Division Circular 14 requires any Support Coordinator and/or Regional Monitor to report suspected exploitation by a participant-appointed representative.

Development of the plan drives the outcomes and the services put in place to ensure the best interest of the individual is the primary focus in meeting individual's needs. Monitoring of plan development and utilization by the Support Coordinator and/or Regional Monitor ensures that the individual is being provided the services and supports needed in order to achieve the identified outcome.

The process for planning and ongoing review of services by both Support Coordination and Regional Monitors controls for situations in which a non-legal representative would not be acting in the best interest of the individual.

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
Transportation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Community Transition Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Case Management	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Day Habilitation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Individual Supports	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Environmental and Vehicle Adaptations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Assistive Technology Devices	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Support Coordination	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Supported Employment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Personal Emergency Response System (PERS)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

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:

Fiscal intermediary services are provided by contract with a non governmental agency. It is a statewide function and was procured through a competitive bidding (RFP) process.

- ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

Fiscal Intermediary services are paid through an annual contract. The contract is adjusted based on the anticipated number of individual that need financial management services. Fiscal Intermediary services cost are set against the number of individuals served as opposed to the service costs. The negotiated rate is set at \$154.58 per person per month. It should be noted that the Fiscal Intermediary acts as the Employer of Record.

- 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:

Acts as employer of record. While the individual has the right to hire and fire staff. The FMS is the actual employer of record and legally employs and dismisses employees at the request of the individual.

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:

Serves as Employer of Record

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:

Acts as employer of record

- 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.

Monitoring is part of the ongoing administrative function of DDD. It is performed on a quarterly basis by a Division team responsible for implementing self-directed services and includes the individual responsible for the contract for the fiscal intermediary function. Input is provided by the regional monitors and support coordinators who have regular contact with individuals and their families.

Oversight is also provided through an annual independent audit. This audit is a requirement of the Single State Agency as delineated in the State Contract Manual in The Department of Human Services' Policy Circular P2.01. Specifically, section 3.09 of this policy requires an annual audit that is agency wide in scope. The audit must be conducted in accordance with the Federal Single Audit Act of 1984, generally accepted auditing standards as specified in the Statements of Auditing Standards issued by the American Institute of Certified Public Accountants (AICPA) and Government Auditing Standards issued by the Comptroller General of the United States.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

- j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of

Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

- Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Transportation	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Community Transition Services	<input type="checkbox"/>
Case Management	<input type="checkbox"/>
Day Habilitation	<input type="checkbox"/>
Individual Supports	<input type="checkbox"/>
Environmental and Vehicle Adaptations	<input type="checkbox"/>
Assistive Technology Devices	<input type="checkbox"/>
Support Coordination	<input checked="" type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Personal Emergency Response System (PERS)	<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:

Regional Monitoring (Case Management) is provided by the Division of Developmental Disabilities, the state agency charged with the daily administration of the waiver. A Regional Monitor must satisfy the qualifications of a QMRP and pass a professional test for the job title as specified by Civil Service. The DDD Regional Monitor is responsible for assuring that the assessment for waiver eligibility and for level of need is complete, assigning the commensurate budget amount, informing the individual/family of their budget, reviewing and approving the service plan and assuring that health and safety factors have been considered. They perform all QMRP functions regarding waiver eligibility and authorization of the service plan. The procurement of information and assistance supports process is consistent with 45 CFR 74. Regional Monitors performance is reviewed annually according to an employee performance evaluation system.

The Regional Monitor, provides information to individuals/families at the orientation meeting. At the orientation the Regional Monitor reviews a power point presentation which details the Division’s self-directed service system. Regional monitors also provide a guide, titled “Road Map”, to the individuals/families to assist them through the planning process should they choose self-direction. In addition, Regional Monitors provide individuals/families a list of qualified providers and the services and supports they offer and they are also given the website for the resource database maintained by Family Resource Network which contains both qualified providers and other generic supports available through other funding mechanisms. Regional Monitors also monitor the individual budget expenditures and services provided. They must approve all plans, budgets and changes in individual’s budgets.

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:

The Regional Monitor provides each individual with the phone number for New Jersey Protection and Advocacy. The following information is made available by NJP&A.

NJP&A is a non-profit organization that provides advocacy services to people with disabilities. NJP&A provides information and referral, technical assistance and training, legal and non-legal advocacy, and outreach and education.

Who is eligible to receive services?

You could be eligible to receive services from NJP&A if:

you have a disability,

you have a problem related to your disability (such as, discrimination or denial of services)

your issue/problem falls within agency priorities.

How long does it take before I hear from someone?

The Intake Unit is open from 9:00 a.m. to 5:00 p.m. Monday through Friday, and includes Spanish speaking staff. Messages that are left on the Intake Unit voice mail system are returned within twenty-four hours. E-mails, faxes and written correspondence are reviewed twice weekly to provide information and referral or to request further information to complete an intake. Walk-ins are addressed immediately.

How will NJP&A decide whether to represent me?

In deciding whether NJP&A will represent you, NJP&A will consider:

The merits of your claim;

Whether your problem falls within one of the priority areas; and

The availability of agency resources.

What is the process?

In order to determine whether NJP&A can assist, you must contact the Intake Unit. The Intake Unit can be reached by telephone, in writing, by fax, e-mail or in person. The Intake Unit will need to obtain information from you about your issue, as well as, other supporting information. The information you provide to the Intake Unit will be reviewed and a decision regarding our assistance can be expected within 5 - 7 business days.

What if I don't agree with the decision?

As a client of NJP&A, or someone requesting services from NJP&A, you have the right to file a grievance if you believe that NJP&A has wrongly denied you assistance with a disability-related matter. If you disagree with the decision not to accept your request for assistance or not to provide further advocacy or legal representation, you may request an appeal by calling or writing NJP&A's Appeal Coordinator at the address or telephone number listed on our Home Page.

Does NJP&A charge a fee for service?

NJP&A does not charge a fee for services. We do, however, accept tax-deductible donations to help cover the costs of providing these services and to expand our programs."

As far as NJP&A's authority, NJP&A is a federally approved/funded P&A pursuant to 42 USC 15041 et seq and 45 CFR 1386 et seq.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

- 1. 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:

This amended waiver has both self-directed and provider managed services. Therefore the individual who chooses to no longer self-directed services may shift to provider managed services within the same waiver.

The regional monitor (state staff) will discuss with the individual the type of provider managed service(s) they are requesting. An example might be a day program (habilitation) funded as a waiver service. The regional monitor will discuss availability with the individual who will select the program they would like to attend. They will continue in self-directed services until the individual is enrolled in the provider managed program, thus ensuring health and safety. In an emergency where the individual requires staff supervision 7 days a week, 24 hours a day the individual will be transitioned into a reserved slot in the Community Care Waiver.

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.

Individuals can be terminated from participant directed services if the following criteria exist

- An assessment reveals that there are risks to health and safety that the individual does not have the capacity to select appropriate services.
- The individual continuously does not comply with the responsibilities set forth in the service plan; doesn't hire qualified staff, doesn't submit timesheets for staff, or regularly exceeds budget despite ongoing efforts to remediate the situation and provide assistance to achieve these tasks
- The individual doesn't agree to comply with requirement for regular monitoring of their plan.

All efforts will be made to work with the individual to comply with requirements. If the individual is involuntarily terminated from participant-direction, they will continue to be eligible for provider directed services internal to the waiver and the regional monitor will assist as the transition occurs. The transition process will be similar to the one described for voluntary termination. The individual will be notified of his/her Right to Fair Hearing and provided the information necessary to appeal this decision..

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

Waiver Year	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
	Number of Participants	Number of Participants
Year 1	<input type="text"/>	<input type="text" value="932"/>
Year 2	<input type="text"/>	<input type="text" value="951"/>
Year 3	<input type="text"/>	<input type="text" value="970"/>
Year 4 (renewal only)	<input type="text"/>	<input type="text" value="989"/>
Year 5 (renewal only)	<input type="text"/>	<input type="text" value="1008"/>

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:

Non governmental fiscal intermediary agency.

- 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:

Individuals/families have the ability to fire staff or discharge any agency that is providing supports and services.

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:*
- 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

- 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.

Budget Authority/Fiscal Management

Participants in Self-Direction have budget authority over the resources allocated to them. They can authorize changes in qualified providers and can choose to hire qualified individuals to support them (using a Fiscal Intermediary) or they can purchase supports from providers. A contracted Fiscal Intermediary supports participants in managing their budget authority. This Fiscal Intermediary acts as the employer of record for individuals whom the participant chooses to hire and pays agencies for services rendered to individuals in Self Direction.

New Jersey is utilizing a methodology based on level of support. Individuals are grouped by the level of support needed and given a maximum budget amount based on their grouping. Costs for the typical service set for each group were established using reasonable and customary rates for these services. The budget amount for each group was determined by an analysis of services required to satisfy the individual need for supports and establishing a maximum budget amount.

New Jersey is utilizing the DDD Individualized Resource Tool. Nationally recognized experts for reliability and validity have evaluated the tool. It assesses individual competencies and determines relative need for services and supports by assessing the individual in the following areas: cognition, communication, self-care and mobility and determines the grouping that would meet the individual's needs. There are seven (7) groups of individuals with similar levels of need determined by the tool. Each grouping is allocated a corresponding budget amount over which the individual has authority.

Level I

Individual needs assistance in community integration skills (e.g., independent use of public transportation).

Level II

Individual needs assistance in shopping, money management and activities of daily living.

Level III

Individual needs assistance in the following areas of daily living dressing, choosing clothing, meal preparation, and understanding money concepts.

Level VI

Individual needs assistance in getting out of bed, ambulating and in the following daily living activities: dressing, eating, managing money.

The budget methodology was made available to the general public in the Division's website. This website is currently under construction but the information will be included when the site is relaunched.

Individuals/families attending orientation meetings are provided information on budget methodology.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

- 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.

Method of Budget Determination

New Jersey is utilizing a methodology that is based on level of need for supports. Individuals are grouped by the level of support needed and given a maximum (up to) budget amount based on their grouping. The budget amount for each group was determined by an analysis of services required to satisfy the individual need for supports and establishing a maximum budget amount. Costs for the typical service set for each group were established using reasonable and customary rates for these services as reflected in current waiver and State Plan cost rate data.

At any time that the individual feels s/he has experienced a change in his/her life situation that requires additional supports s/he may contact the Support Coordinator to request a reassessment of need. If it is determined that the need is temporary due to an acute situation (i.e. hospitalization of a support person or caregiver) a patch (short term fiscal increase in the budget) may be offered to ameliorate the situation prior to an assessment. This will ensure that the assessment is valid for the individual over time as opposed to a false reading due to a temporary situational stressor. If this is not the situation and/or the individual requests a reassessment, the tool will be reapplied and the results communicated in writing to the individual with the rights to and process for requesting a fair hearing.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

- 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

- 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:

The fiscal intermediary has the service plan and the budget authorization for each individual and is responsible for reporting issues of over expenditures to the support coordinator who works with the individual and family to ameliorate the situation. The individual participant receives a monthly report from the fiscal intermediary. The support coordinator receives a copy and is responsible for working with the individual regarding use of their budget.

The fiscal agent "locks" the budgets not allowing payment for services rendered unless there are funds available in the individual's budget. The fiscal agent posts expenditures directly into an individual's electronic plan of care once it has been determined that funds are available in the individual's budget. The expenditures are then available for review by the Regional Monitor and Support Coordinator both by outcome and service. The budgets are monitored monthly by the fiscal agent, the Division's Regional Monitor and the individual's Support Coordinator. In addition, the Regional Monitors and Support Coordinators have the ability to view the detail in regards to the dates and times services were provided.

Families/individuals, on a monthly basis received expenditure reports from the fiscal agent in order to assist them in monitoring the individual's budget. The fiscal agent also, on a monthly basis, forwards the reports sent to the individuals/families to the Regional Monitor and Support Coordinator highlighting those individuals who are close to reaching the budget

cap in regards to expenditures.

Underutilization is monitored in the same manner as expenditures are monitored. In addition, the electronic record generates a report which highlights those individuals for whom there is no posting of expenditures. There is also an overview of expenditure report which provides information regarding percentage of expenditure in relation to the individual's budget. (The % will be added to the report in the future)

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.

At the time participants apply for DDD eligibility intake, they are notified in writing of the opportunity to request a Fair Hearing. In addition, the Division Case Manager or Regional Monitor, informs the individual of his/her Fair Hearing Rights at the time of the initial processing of waiver eligibility. This is done in accordance with 42 CFR 431 Subpart E, and NJ's Division Circular #37 (N.J.A.C. 10:48-1) which references the Fair Hearing process and addresses appeal procedures annually at the service plan.

Should an individual receive an adverse determination of choice of HCBS vs. institutional needs s/he will be promptly notified of his/her right to a Fair Hearing by his/her case manager in writing.

When services are denied, suspended, reduced or terminated against the wishes of the individual, s/he will be notified in writing by her/his Case Manager or Regional Monitor of the Right to Fair Hearing. Assistance in an appeal would be rendered by family members, guardians and/or advocates.

Notices of adverse actions and the opportunity to request a Fair Hearing are maintained in the individual's file in the DDD regional offices.

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.

The Division of Developmental Disabilities, the Single State Medicaid Agency component charged with the daily administration of the waiver, conducts appeal hearings in accordance with N.J.A.C. 10:48-1.1 through 1.4. This is done to encourage and permit the early resolution of disputes and, where that is not possible, to identify the steps for review by the appropriate authority. It should be noted that the following describes the appeal process available to any individual seeking services through DDD. As stated in the text any waiver consumer may opt to utilize or opt out of this process and receive a Fair Hearing.

All disputes and disagreements with service components of the Division of Developmental Disabilities involving a competent adult receiving services from the Division, the guardian of a minor or incompetent adult, the proposed guardian, a licensee of the Division or an authorized representative of a competent adult, guardian of a minor or incompetent adult may be addressed in this manner.

Division staff are responsible for informing persons served and their families/guardians about appeals including the right to fair

hearing and to supply them with copies of the appeal procedure. Non-contested matters shall be referred to administrative review.

A request for a hearing shall be in writing and shall contain the information required below. This information shall be the basis of an initial pleading should the matter be transmitted to the Office of Administrative Law (OAL). The request shall include:

- i. Name and address of appellant;
- ii. Name and address of person with developmental disabilities, if the appeal is made by the person's legal guardian;
- iii. A brief statement of the matter under appeal;
- iv. A list of potential witnesses; and
- v. Reference to the law, rule, regulation or policy alleged to be violated.

The appeal shall be made to the administrative head of the component who shall review the appeal and decide if it is a contested or non-contested matter.

With regards to dispute resolution under this administrative code, a settlement may be accepted by the chairperson of an informal conference or the review officer in an administrative review in the same manner as an Administrative Law Judge, in the definition of settlement at N.J.A.C. 10:48-1.2.

If agreement is reached, a settlement agreement shall be negotiated and the terms of the agreement shall be made in writing. The settlement shall be time limited or otherwise note when the terms of the agreement shall have been satisfied.

If no settlement is possible, the administrative head of the component shall notify the appellant that he or she may submit a written request to the Assistant Commissioner, Division of Developmental Disabilities to transmit the matter for an administrative appeal before the OAL.

Those matters determined to be contested shall be referred to the Office of Administrative Law (OAL) for a hearing, in accordance with the Administrative Procedure Act at N.J.S.A. 52:14B-2(b) and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

If the contested matter is not settled the Division Assistant Commissioner shall transmit the matter to the Office of Administrative Law.

A decision rendered by OAL shall be adopted, rejected or modified by the Assistant Commissioner, Division of Developmental Disabilities within 45 days of its receipt (N.J.S.A. 52:14B-10(c)). This shall be construed as constituting the final administrative decision of the matter under appeal.

Upon issuance, the final administrative decision shall be sent to the involved parties with notice that any further appeal must be to the Appellate Division of the Superior Court of New Jersey.

Timelines are as follows:

1. Appeals of waiver services, denial of waiver eligibility, or level of waiver services must be made, in writing, within 20 days from the date of the notice of such action or after the conclusion of an alternate dispute resolution conference that did not result in settlement of all issues.
2. If dispute resolution is requested, the alternate dispute resolution conference shall be scheduled no more than 20 working-days from the date that the request for alternate dispute resolution is received. Extension of the conference date beyond 20 days may only occur upon mutual agreement of both parties. The summary shall be provided to the appellant within 20 working-days of the conference. The parties will then negotiate a settlement and a settlement agreement will conclude the matter.
3. If the alternate dispute resolution conference is waived, or if settlement is not reached, or at any time in the process, the appellant may request a fair hearing.
4. The Division shall forward the request to DMAHS within five working days. DMAHS will forward the request to the Office of Administrative Law. Forty-five days after receipt of the Administrative Law Judge's findings, the Director of DMAHS will issue a Final Agency Decision.

Individuals are told dispute resolution is not a pre-cursor to a fair hearing. Per Division Circular 37, section 2.1(b): "The alternate dispute resolution conference is not a requirement or prerequisite to the fair hearing." Division Circular #37, which corresponds to N.J.A.C. 10:48, is current as of May 2007.

In an effort to even more clearly delineate Fair Hearing rights DDD is in the process of developing Division Circular #37A. DC #37A will focus on the Fair Hearing process to further ensure that the individual understands his/ her Fair Hearing rights. This Circular will be presented to the Procedure and Policy Committee in October. Dependent upon the comments and corrections the Circular should

be available within 6 months of the initial review.

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:

Department of Human Services, Division of Developmental Disabilities

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).

In addition to participants receiving information on the Fair Hearing process during DDD eligibility intake they will also receive information regarding NJ's Grievance/Complaint line. NJ's grievance/complaint line addresses issues that fall outside the scope of the Fair Hearing process. Participants will receive (from the Intake worker in the mailed Intake Packet and annually at the service plan) a phone number to report grievances and complaints. This phone number will also be on the NJ DDD State website for use by other stakeholders. The types of grievances or complaints that may be registered include:

- a. reportable Unusual Incidents
- b. complaints about DDD
- c. complaints about service providers
- d. other complaints/grievances that fall outside the scope of the Fair Hearing process

NJ DDD has the operational responsibility for the grievance/complaint system. In order to better facilitate the current system process NJ is developing a 24 hour electronic answering service to screen the initial calls. All participants will receive the grievance/complaint number at intake and be informed that utilization of the line is not a pre-requisite or substitute for a Fair Hearing and only addresses issues that fall outside the scope of the Fair Hearing process.

Currently the DDD employee answering the call during business hours determines the appropriate region and refers the caller to the regional office to process the complaint. After hours the phone call is routed to an answering service that in the case of an emergency contacts a Regional DDD staff functioning as the after hours On-Call staff. All other calls are recorded and forwarded to the regional office the following morning. The regional office distributes the messages to the appropriate case manager for follow up.

Employees hired to work in the On-Call position have been employed by the Division for at least one year and are familiar with the Fair Hearing process. The DDD employee will record the complaint in an electronic database (currently under development) according to a specified coding system and complete necessary documentation.

It is expected that the follow-up action is completed during the same business day or the next business day if the call occurs after hours, on a weekend or State holiday. Actions taken are currently recorded in individual consumer's progress notes.

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).

Types of Incidents that require reporting:

The Department of Human Services, the single state Medicaid agency, establishes policies for the reporting of critical incidents for all of its divisions, including the Division of Developmental Disabilities.

Beginning October 1, 2004, the Department issued Administrative Order 2:05 - Unusual Incident Reporting and Management System (UIRMS). This Order initially applied to State Operated Facilities. On October 1, 2005, the scope of the order was officially extended to include community programs including all programs under contract with the Department through the Division of Developmental Disabilities or regulated by Developmental Disabilities Licensing.

The Administrative Order defines the types of incidents that will be reported and prescribes the codes that will be used to categorize them. The following categories of incidents are required to be reported:

Abuse (physical, sexual, verbal/psychological/mistreatment)

Assault (service recipient (SR) to SR, SR to staff, SR to other, other to SR)

Contraband (alcohol, drugs, weapons, dangerous items)

Criminal Activity (by both SR and staff)

Danielle's Law (potentially life threatening events requiring 911 calls)

Death (unexpected and expected)

Elopement (of legally defined SRs)

Exploitation

Injury (accidental, self-injurious, pica, unknown origin, restraint-related)

Medical (medication or treatment errors, reportable diseases)

Neglect

Operational(Losses to SRs, Fires, staff shortages that pose threat, environmental, operational breakdowns, e.g., loss of utilities)

Restraint Use (either no prior approval or in violation of approved plan or used to remove SR from harm)

Rights Violation

Sexual Assault/Contact (no caretaker involvement differentiates this from sexual abuse)

Suicide Attempt

Walk away (SR has no criminal status)

Each incident is assigned both a category, for example, Abuse, and a code, for example AB116 (physical abuse with a major injury) that automatically assigns a "level" to the incident. The most serious incidents are assigned a level of A+, for example AB116 is an A+ level incident. The least serious reportable incidents fall within the level B category. The levels are generally a function of injury level, with major injuries defining what is an A+ incident and minor injuries defining what is less serious.

Reported by:

The Administrative Order applies to all service providers under contract with, and/or regulated or licensed by the Department of Human Services or its Divisions, as well as all staff of the Division of Developmental Disabilities.

Reported to:

Using a standardized form, staff, in the agencies that fall within the scope of the Administrative order, who witness or become aware of an incident, report the types of incidents described above via fax to the applicable DDD regional office Unusual Incident Report (UIR) Coordinator. This is required whether or not corrective action has already been taken. Staff of the Division who witness or become aware of an incident may also report similarly to their respective Regional Office UIR Coordinator.

Regional Office staff review each incident report submitted for readability and appropriate coding and enter it into a Department designed, web-based database (called UIRMS). Corrections are obtained from agencies when necessary. The UIRMS database is programmed to automatically distribute alerts via emails that contain hyperlinks to the full incident reports. The alerts are sent to those staff throughout the Division and Department who have been assigned (and programmed) to receive the alerts for review and possible action. Additional staff can be added or deleted to receive alerts at any time by request of an administrator. Each incident report lists the names of all the people who have automatically been sent the incident report as well as additional people have been notified about the report by Regional Office, e.g., family, police, guardians, etc.

Reporting Timelines

Information about level "A+" incidents must be conveyed immediately by telephone to a designated person in the Regional offices.

Written reports of A+ and A incidents shall be forwarded to the Regional Offices the same working day during normal working hours. If the incident occurs after regular working hours, the written incident report shall be forwarded the next working day. Written

reports of B incidents shall be forwarded to the Regional office the next working day following the date of the incident.

Written information regarding level A+ incidents must be entered into the Department's database as soon as the information is made available to the Regional office.

"A" level incidents must be entered into the Department's database by the end of the workday it is received.

Level "B" incidents must be entered into the Department's database by the end of the workday following the receipt of information regarding the incident.

- 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.

The Division has developed a two-page pamphlet that discusses abuse, neglect, exploitation, and other incidents and how they are reported and investigated. It includes the telephone numbers of the Regional Offices and encourages families to report incidents to their respective Case Managers/Regional Monitors or Regional Office administrators.

The Division's policy on incident reporting, Division Circular #14, requires providers and/or Case Managers/Regional Monitors, as applicable, to review reporting procedures with the individual and his/her legal guardian and family annually.

- 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.

All community-based incidents are received automatically, regardless of level, by the Special Response Unit (SRU). The SRU reports to the Office of Program Compliance (OPC) in the Office of Program Integrity and Accountability (OPIA) in the Department of Human Services.

The SRU directly investigates the most serious incidents of abuse, neglect and exploitation. It also reviews the investigations conducted by agencies of less serious incidents.

Within 60 days of the receipt of the initial incident report, the SRU completes its investigation. It then disseminates its findings and concerns to the provider agency and to Division staff.

- 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 Single State Agency, through the Special Response Unit, the Developmental Disabilities Licensing, the Critical Incident Management Unit, the Division of Developmental Disabilities (the component charged with the responsibility for daily administration of the waiver) and the URMS system will have oversight of the reporting of and response to critical incidents or events that affect waiver participants.

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).

Division Circular #34 "Behavior Support Plans" provides guidelines by which Division components and service providers will develop, implement, and evaluate behavior support plans. It applies to all components of the Division and agencies and entities under contract with the Division or regulated by the Department, who provide services to Division eligible individuals.

Division Circular #34 outlines the need for a sound functional analysis and the use of currently accepted behavioral practices including abiding by the least restrictive treatment model. Plans may not employ retaliation or retribution but may contain aversive elements with appropriate controls and approval. To protect individuals from unnecessary interventions, the plans must be based upon adequate behavior analysis and include relevant empirical measures of outcomes to justify the redesign or continuation of the plan. It is the responsibility of the Interdisciplinary Team (IDT) to identify any behavioral risk elements associated with the individual's behavior or with the proposed behavior support techniques. Behavioral support techniques that may be utilized after a review of the potential risk to the individual and others include the following: response cost, environmental alteration, routine alteration, restricted rights, physical prompting/guidance, contingent presentation of a non-preferred sensory or physical stimuli, physical restraint, overcorrection or required physical activity, and exclusionary time out over 5 minutes or the use of a time out room (only as authorized by the Division Assistant Commissioner).

Division Circular #34 states that Division components and service providers shall be authorized to implement behavior plans after having demonstrated the on-going capability to do so, including but not limited to having adequate resources for implementation, control, and evaluation of behavioral plans as well as adequate staff training. Behavior supports will not be used for the convenience of staff or as a substitute for activities or more appropriate treatment. Prior to the implementation of a behavior support plan, staff who are authorized to implement the plan shall complete training in Behavioral Supports, Abuse and Neglect policies and documented training on the behavior support plan itself. In addition, staff authorized to implement behavior support plans will be monitored on a periodic basis to ensure competency, including the ability to identify target behaviors, implement the techniques, and properly collect data.

Every Division component or service provider that may find it necessary to develop or implement a behavior support plan shall either submit a Behavior Support Policy and Procedure Manual to the Division Assistant Commissioner for approval or develop a Memorandum of Understanding with the Division's Community Services Regional Office. The MOU will specify how the service provider will adopt and utilize the Division's Community Services Behavior Manual.

A Behavior Support Policy and Procedure Manual shall include the following:

1. Identification of the specific behavioral support techniques to be used by the Division component or service provider.
2. A plan to obtain expertise and training in alternate or additional behavior support techniques, in the event that the identified behavioral support techniques prove ineffective.
3. Clinical guidelines for behavioral assessment.
4. Staff training programs or procedures to assure staff competence and the retention of skills.
5. A description of the approval process, including specification of the Human Rights Committee and Behavior Support Committee that would be utilized.
6. Designation of responsibility for the implementation, monitoring and documentation of behavior support plans.
7. An identified location where a central file of all behavior support plans will be maintained and available for review.

A Memorandum of Understanding (MOU) shall address the following:

1. The Service provider and Regional Office staff responsibilities for the identification of a target behavior and development of a behavior support plan.
 2. A description of the method for obtaining required approvals, specifying the Human Rights Committee and Behavior Support Committee that would be utilized.
 3. An outline, detailing staff training.
 4. Designation of responsibility for the implementation, monitoring and documentation of behavior support plans.
- An identified location where a central file of all behavior support plans will be maintained and available for review.

Unauthorized Restraints are detected in the following manner:

An UIR (Unusual Incident Reporting) is required for all unauthorized use and use which results in an injury or misuse (Division Circular (DC) #14, "Reporting Unusual Incidents" & DC #19, "Personal Control Techniques").

Prior to or at the time of the initial authorization, a physician must certify that the technique to be employed is not medically contra-indicated for the individual (DC19).

Human Rights Committee (HRC) reviews each emergency use and forwards results with recommendation regarding the use of the restraint to the RAD, Regional Administrator (RA) and Department of Human Services, Office of Licensing OOL, within 10 days of the HRC review (N.J.A.C. 10:42-3.3).

Case Management review and reporting of findings as well as OOL and SRU findings via home inspections and/or

investigation process.

- 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 Assistant Commissioner of the Division of Developmental Disabilities, the agency administering daily waiver operations, shall appoint a Behavioral Policy Review Committee which shall review the Behavior Support Policy and Procedure Manual or MOU. An MOU shall require approval by the Division's Community Services Regional Office prior to review by the committee.

Safeguards concerning the use of restraints and seclusion are specifically delineated in Division Circular #34 which contains the components required in the behavior support plan, approval requirements, implementation, monitoring, and documentation. It also includes provisions for quality oversight and outcome measures, to identify and track overall trends. The Division's Regional Behavior Support Committee shall review proposed behavior support plans against the requirements of Division Circular #34.

Unauthorized Use is detected by:

IDT special review meeting required of mechanical restraint incidents to determine if Alternative methods are necessary to handle behavior. If a behavior plan is needed N.J.A.C.-3.3(b) 13 and results of review are forwarded to the HRC.

The Human Rights Committee is required to review all emergency use and forward the results to the RAD, RA and OOL per N.J.A.C.-3.3(b) 14.

Seclusion (placing an individual alone in a locked room) is a prohibited practice (DC#34, "Behavior Modification Programming"). It would require an Unusual Incident Report as abuse.

Overuse is detected by:

An IDT review of mechanical restraint incidents to determine if a program is needed as recorded above.

The IDT must review if personal control techniques are used 3 times or more in a six month period, (Division Circular (DC), #19, "Personal Control Techniques").

Inappropriate/ineffective use is detected by:

Highly restrictive mechanical restraints require continual observation, N.J.A.C. 10:42-3.3-(b)6 and

In accordance with N.J.A.C. 10:42-3.3-(b)7 - While in mechanical restraint, the individual must be checked by a trained staff member no less than every 15 minutes to assess if continued use is necessary and if applied in accordance with principles of good body alignment – concern for circulation and allowance for position change.

Ensuring that all State requirements are followed:

- The Behavior Policy Review Committee (BPRC) is responsible to review the agency's restraint policies and procedures and make recommendations to the Division for agencies planning to use restraints (Division Circular 34).
- DDD may terminate agency approval for restraint usage if any requirements of Division policies or restraint regulations are violated - N.J.A.C. 10:42-1.4(k).
- Only staff successfully trained may apply, monitor and release mechanical restraints or Personal Control Techniques (N.J.A.C. 10:42 & DC 19).
- All DCs and agencies approved by the Division to use mechanical restraints and/or personal control techniques must comply with all State statutes regarding individual's rights, in accordance with N.J.S.A. 30:6D-5.
- As part of contractual agreements with the State, agencies agree to adhere to all Division regulations and policies and procedures relating to services provided to Division eligible individuals.
- Agency use requires reviews and recommendation of approvals from the HRC, Behavior Support Committee and the IDT (.
- Restraint reporting from the DCs includes all mechanical restraint and personal control technique use excluding medical use from which a monthly report is generated and submitted to P & A via Bill Holloway.

The following information regarding trend analysis and timeframes is taken directly from the CMS approved Plan of Compliance for the evidentiary review in preparation for the waiver renewal.

The Office of Program Integrity and Accountability (OPIA) has developed a risk management system that will aggregate, analyze, and provide summaries of problem remediation to ensure the health and safety of waiver participants. The following represents an overview of the system designed to achieve a broad proactive approach to identify, and minimize risk to an individual's health and safety:

- a. The system includes a Quality Indicators Report that is issued quarterly, and includes the following domains: incident reporting, abuse and neglect investigation, inspection and program review, and fiscal integrity.
- b. Each domain has associated indicators of health, safety and welfare.
- c. Data on these indicators is provided by the appropriate OPIA or Division component, to the Critical Incident

Management Unit for inclusion in the quality indicators report

d. Upon receipt of the Quality Indicators Report, the appropriate Unit/Division will conduct a root cause analysis of the data associated with its Unit, and prepare a report of its findings for discussion.

e. A Council on Systemic Risk comprised of a cross section of Department managers; analyze the data, determine course of action, and institute a timeline for completion of action steps.

a. Quarterly review of data by the Council will measure the success of the action plan.

b. Improved outcomes for waiver participants will continue to be measured.

Timeframes for implementation are as follows:

a. By June 1, 2008 the Council on Systemic Risk will have its first organizing meeting

b. By June 15, 2008 internal and external stakeholders will have knowledge of the Risk Management System, and the data being analyzed.

c. By July 1, 2008 the Council will have its first quarterly meeting to review data.

• Coordination between the four divisions involved in incident reporting, investigation, and resolution should be documented through cross-referenced databases and reports to eliminate the possibility of conflicting correction plans and/or duplication of effort.

a. By October 1, 2008 CIMU will generate a quarterly report to DDD, OOL and SRU that provides trending information through the aggregation of incidents by region, type, investigative assignment and findings.

b. By July 1, 2009 the Department will create a data field in the UIRMS system that allows for the entry & querying of final actions taken re. the disposition of cases.

c. By October 1, 2009 CIMU will add to the quarterly report described in a. the information regarding actions taken in response to findings.

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.

Division Circular #34 (Behavior Support Plans) expressly prohibits the use of electric shock, ammonia, pepper spray and mace. Seclusion (placing an individual alone in a locked room) is a prohibited practice. Division components and service providers must insure that behavior support plans do not employ retaliation or retribution.

Moreover, the use of other restrictive interventions is prohibited, except when used as an element of an approved behavior support plan. Per the Department of Human Services Administrative Order 2:05, the unauthorized use of restrictive interventions is a reportable critical incident. A full discussion of the critical incident reporting and management system is found at Appendix G-1,a. through e..

Behavior support plans, including those with restrictive interventions, may only be implemented by Division components or service providers whose behavior support policy and procedure has been reviewed and approved by the Assistant Commissioner.

The approval and oversight requirements of Division Circular #34 apply to a comprehensive array of behavior support plan interventions, including those that restrict movement, limit access, infringe upon rights or make use of aversive elements. Division Circular #34 defines these as Behavioral Risk Elements, and they are enumerated as follows:

- token or point systems utilizing response cost or the loss of tokens, points or privileges. (This does not include plans only utilizing positive reinforcement or extinction.)

- substantive alteration to the usual environment, for the specific purpose of behavioral control. This includes the utilization of clothing or physical barriers to restrict access or impede movement, and the use of indirect monitoring designed to track movement or activity.
- substantive alteration to the usual routine, for the specific purpose of behavioral control, including meal times or occasions for social contact.
- restricted rights, including limited access to the typical environment or personal property.
- the use of physical prompting and/or manual guidance to overcome significant resistance.
- contingent presentation of non-preferred sensory or physical stimuli; intended to alter the frequency, intensity or duration of a behavior.
- physical restraint of the body, by any means, as part of a behavior support plan.
- overcorrection or contingently required physical activity; intended to alter the frequency, intensity or duration of a behavior.
- any exclusionary time out procedure over five (5) minutes in duration, or the use of a time out room when specifically approved by the Assistant Commissioner.

Behavior Support Plan - Approval

Prior to its implementation, a behavior support plan must attain the required approvals. Approvals are valid for a period not to exceed twelve (12) months following the date of implementation. Plans continuing beyond twelve (12) months must be updated, revised and submitted to the Inter-disciplinary Team (IDT) for consideration of re-approval. Re-approval of a behavior support plan is predicated upon there having been a clinically significant reduction of the target behavior or documented clinical justification for the continuance of the plan.

Approval requirements for behavior support plans with restrictive interventions include:

- Approval of the IDT. The behavior support plans shall be consistent with and incorporated into the individuals' Service Plan.
- Medical review, if required based upon evaluation of the IDT.
- A review of the clinical and technical appropriateness of the plan by the Behavior Support Committee (BSC), in accordance with Division Circular #18. These reviews must be conducted at least every thirty (30) days for the first ninety (90) days and at least every ninety (90) days thereafter.
- A review by the Human Rights Committee (HRC). In accordance with Division Circular #5 these advisory bodies are charged with protecting and advocating for human and civil rights.
- Informed Consent which is not coerced, in accordance with Division Circular #41.
- Approval by the CEO or Regional Administrator (RA) having administrative authority over the Division Component or service provider responsible to implement the behavior support plan.

Behavior Support Plan - Policy and Procedure

Every Division component or service provider implementing a behavior support plan shall have their Behavior Support Policy and Procedures reviewed and approved by the Assistant Commissioner. The policy must describe the plan development and approval processes, documentation requirements / timeframes, and describe the processes to:

- augment staff professionalism and skill;
- conduct behavioral assessment and functional analysis of target behaviors;
- maintain staff training programs to provide both an overview of general behavioral supports and training on any specific behavior support plan(s);
- assign responsibility for the implementation, monitoring and documentation of behavior support plans. Monitoring of behavior support plans shall include direct observation of staff implementation, including the timely and accurate collection and recording of plan related data;
- implement a quality oversight system, based upon the administrative auditing of individual behavior support plans. Required elements include staff training, data collection practices, documentation of progress and quality of life indicators, documentation of approvals and ongoing clinical (BSC) and Human Rights (HRC) reviews.

Behavior Support Plan - Credentials and Training

Behavior support plans with restrictive interventions shall be developed by or reviewed, approved and operate under the supervision of an individual with at least a Master's degree in psychology, special education, guidance and counseling, social work, or in a related field, along with at least one year of experience in the development and implementation of behavior support plans for individuals who have developmental disabilities.

Only successfully trained staff may implement a behavior support plan. It shall be documented that staff directly implementing the plan shall have completed the following trainings:

- Orientation to behavioral supports, using the curriculum described in the approved Behavior Support Policy and Procedure.
- Orientation to Abuse and Neglect policies.
- Training on the specific behavior support plan. This training shall insure that, at a minimum, staff responsible for the direct implementation of the behavior support plan can identify target behaviors, implement all behavior support techniques and properly collect and record data.

Behavior Support Plan - Additional Required Elements and Safeguards

All approved behavior support plans shall be consistent with and incorporated into the individuals Service Plan. Division Circular #35 (Service Plan) requires that every program, support and/or service outlined in the Service Plan shall operate in accordance with generally accepted professional standards in a setting that is least restrictive of personal liberty. When an individual's rights are restricted, each restriction and the justification for the restriction shall be documented in the Service Plan. The Service Plan shall also indicate when restrictions may be lessened or eliminated. The restriction shall be

reviewed in accordance with Division Circular #5 "Human Rights". The individual or legal guardian shall be advised of their right to appeal any restriction of rights.

Division Circular #34 requires that, to protect individuals from ineffective or unnecessary interventions, behavior support plans must be based upon adequate behavioral analysis, including functional analysis of the behavior. This includes a review of the conditions and factors impacting the behavior, the function and motivation for behavior, and the identification of reinforcement. There shall be an assessment of the individual's communication skills, and the role that communicative deficits, if any, play in relationship to the function of the target behavior.

In cases where a potential medical cause for the target behavior has been identified, there shall be a documented review by a medical professional considering the relevant medical status of the person. The documentation shall indicate that medical causes for the behavior have been evaluated and ruled out or are being further explored and addressed. Current medications which are relevant to the target behavior, the reasons for taking the medications and any side effects of the medication will be identified.

- 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:

The progress of behavior support plans must be documented and is subject to ongoing oversight and review. Division Circular #34 requires that behavior support plans must be reviewed periodically and shall be revised if found to be ineffective. These reviews of plan effectiveness shall compare current data-based measures with those obtained prior to the plan implementation or its latest revision.

Behavior Support Documentation

For plans which include restrictive interventions, on at least a monthly basis, documentation shall be entered into the client record reflecting the behavior support plan progress and significant events related to the training or implementation of that plan. This documentation of progress shall be based upon a comparison of current data-based measures with those obtained prior to the plan implementation or its latest revision.

At least once per quarter, if the monthly documentation does not substantiate a progression towards or achievement of the desired behavioral effect, then this documentation shall note any potential reasons that have been identified.

Additionally, at least once per quarter, documentation shall be entered into the client record reviewing some of the identified quality of life outcome measures. Two successive quarters of poor outcomes shall require an IDT review of the behavior support plan and the identified quality of life outcome measures.

Behavior Support Plan Oversight

Oversight of behavior plans with restrictive interventions is conducted via the ongoing reviews of the IDT, BSC and HRC. Reviews shall consider data based documentation of behavior support plan progress. Additionally, these plans shall be subject to audit by the Division, an authorized Department representative or by the designated licensing entity.

IDT reviews occur at least annually. As a part of the Service Plan, the behavior support plan is reviewed to insure that when an individual's rights are restricted, each restriction and the justification for the restriction shall be documented in the Service Plan. The Service Plan shall also indicate when restrictions may be lessened or eliminated. The restriction shall be reviewed in accordance with Division Circular #5 "Human Rights". The individual or legal guardian shall be advised of their right to appeal any restriction of rights.

Each behavior support plan shall be valid for a period not to exceed 12 months after implementation. Plans may be updated and submitted for re-approval after 12 months, if periodic reviews document a continued clinically significant reduction of the target behavior, or the Interdisciplinary Team (IDT) and Behavior Support Committee (BSC) document specific reasons for the plan to continue.

In accordance with Division Circular #18, if re-approved, behavior support plans with restrictive interventions require ongoing Behavior Support Committee review every 90 days and must be reviewed by the Human Rights Committee in accordance with Division Circular #5. Informed Consent must have been obtained in accordance with Division Circular #41.

Quality Audits

Division Circular #34 requires that each Division component or service provider shall conduct audits of individual behavior support plans and compile them into an overall quality assessment survey; to identify and track trends and assess the overall implementation and efficacy of their behavioral interventions.

This audit is to be based on at least twenty (20) percent of the existing behavior support plans, every twelve (12) months. Service providers with fewer than ten (10) plans shall review at least three (3) plans every twelve (12) months, if at least three (3) plans exist.

The behavior support plans selected for these reviews shall be representative of the types of plans and the settings within which they operate at the Division component or service provider's facility.

Required review elements include staff training, data collection practices, documentation of progress and quality of life indicators, documentation of required approvals and of ongoing clinical (BSC) and Human Rights (HRC) reviews.

Inappropriate/ineffective use is detected by:

Per the Department of Human Services Administrative Order (AO) 2:05, the unauthorized use of restrictive interventions

is a reportable critical incident.

In addition, AO 2:05 requires the reporting of incidents in many other categories that may be indicative of inappropriate or ineffective use of restrictive interventions such as abuse, assault, major and moderate accidental injuries and injuries of unknown origin, injuries associated with self injurious behaviors, neglect, and death. All of these incident types require follow up actions to ameliorate cause; some require full investigations, such as abuse, neglect, unexpected deaths, and major injuries due to self injurious behavior or where the cause is unknown.

Periodically, incident data is aggregated by service recipient for the purpose of identifying trends which may be indicative of inappropriate or ineffective 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.

First-line responsibility for monitoring participant medication lies with the medical professionals who prescribe the medications. The following safeguards are in place as second-line monitoring practices:

- All medications are documented in the participant's Service Plan. Information includes the name of the medication, the dosage, frequency and prescribing physician. The Service Plan is reviewed at least annually by the Interdisciplinary Team, more frequently if there are changes.
- All participants are required to have an annual physical examination per N.J.A.C. 10:44A. The Primary Care Physician will review all of the individual's medications at the time of the exam.
- Licensed Residential Facilities are required to have a medication reference book, current within three years and written for laypersons, which shall include information on side effects and drug interactions in accordance with N.J.A.C. 10:44A and N.J.A.C. 10:44C.
- Licensed Residential Facilities and Community Care Residences are required to report drug interactions to the DDD Case Manager as stated in N.J.A.C. 10:44A, N.J.A.C. 10:44B, and N.J.A.C. 10:44C.
- All staff administering medication are required to attend "the DDD Medication Training". The curriculum includes lessons on Categories and Effects of Medication and Observing and Reporting.
- Case Managers visit Licensed Residential Facilities quarterly and Community Care Residences monthly. Case Managers review medication changes and medication administration records during the course of the visit.
- Case Managers make referrals to the DDD Regional nurses for consultation, assessment, and training when necessary.
- N.J.A.C. 10:44A requires that PRN medication only be administered when current (within 1 year) physician's orders are present stating the name of the medication, dosage, specification of intervals between dosages, maximum amount to be given in a 24 hour period, a stop date when appropriate, and under what conditions the PRN medication shall be administered. N.J.A.C. 10:44A requires documentation of all PRN medication on the medication administration record and the communication of the administration of the PRN medication to the on-coming shift.

The scope of the medication monitoring is found at all three rules enforced by DDL regarding individuals with developmental disabilities: N.J.A.C. 10:44A, N.J.A.C. 44B and N.J.A.C. 10:47. In each rule all medications administered to individuals by staff must conform to the requirements of the rule, which include, in general, standards for appropriate storage, appropriate handling, appropriate administration, appropriate monitoring and appropriate recording. During a licensing inspection, usage patterns are determined by an examination of all elements listed above for a sample of individuals living in each residence. During case management visits usage patterns are also identified often by observation of medication administration. There is no separate examination for psychotropic medications all medication issues in community settings are otherwise covered by one set of standards (in each rule) pertaining to all medications.

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.

Medication administration is prescribed by state administrative code N.J.A.C. 10:44A, N.J.A.C. 10:44B, and N.J.A.C. 10:44C. The details are described in section i. above.

Licensed Residential Facilities contracted with the Division of Developmental Disabilities are required to develop their own policies and procedures regarding medication management. These policies and procedures are reviewed and approved by Developmental Disabilities Licensing (DDL)

Drug Information Sheets, provided as either package inserts or directly from the pharmacy, must be maintained for each prescribed medication.

In most cases, the pharmacy maintains a list of medications for each individual. When a new prescription is presented, the pharmacy's internal safeguarding system will alert the pharmacist if drugs are contraindicated.

DDD Case Managers visit licensed residential facilities quarterly. Medication administration, documentation and storage will be monitored on a random sample basis, ensuring that each waiver participant's medication regimen is monitored at least twice in a calendar year. It is the provider's responsibility to inform the Case manager of any new or changed medications. The Case Manager will ensure that the supporting documentation is present. Medication administration audits may also be initiated if there are significant changes in an individual's health, behavior or medication regimen. A UIR will be generated if medication errors are discovered that had the potential to cause harm or resulted in the need for medical treatment. Findings are documented on the ALA visit form which will become the Waiver Monitoring Tool and be completed electronically. Regional nurses are available for additional assessment, consultation or training.

Where Community Care Residences administer medications, it is necessary to note any medication changes/new medications during monthly visits. If a concern arises, a referral shall be made to the Regional nurse for assessment, consultation, or training.

The state gathers data regarding potentially harmful practices by a number of processes. These include the reporting of Unusual Incidents involving medication errors, case management visits, visits by regional nurses, Special Response Unit investigations, monitoring by agency licensees (including monitoring by nurses if employed by the licensee) and licensing inspections.

The state will utilize the plan for improved remediation of Unusual Incidents outlined below to identify trends and patterns to support improvement strategies.

The Office of Program Integrity and Accountability (OPIA) has developed a risk management system that will aggregate, analyze, and provide summaries of problem remediation to ensure the health and safety of waiver participants. The following represents an overview of the system designed to achieve a broad proactive approach to identify, and minimize risk to an individual's health and safety:

- a. The system includes a Quality Indicators Report that is issued quarterly, and includes the following domains: incident reporting, abuse and neglect investigation, inspection and program review, and fiscal integrity.
- b. Each domain has associated indicators of health, safety and welfare.
- c. Data on these indicators is provided by the appropriate OPIA or Division component, to the Critical Incident Management Unit for inclusion in the quality indicators report
- d. Upon receipt of the Quality Indicators Report, the appropriate Unit/Division will conduct a root cause analysis of the data associated with its Unit, and prepare a report of its findings for discussion.
- e. A Council on Systemic Risk comprised of a cross section of Department managers; analyze the data, determine course of action, and institute a timeline for completion of action steps.
- c. Quarterly review of data by the Council will measure the success of the action plan.
- d. Improved outcomes for waiver participants will continue to be measured.

Timeframes for implementation are as follows:

- a. By June 1, 2008 the Council on Systemic Risk will have its first organizing meeting
- b. By June 15, 2008 internal and external stakeholders will have knowledge of the Risk Management System, and the data being analyzed.
- c. By July 1, 2008 the Council will have its first quarterly meeting to review data.

• Coordination between the four divisions involved in incident reporting, investigation, and resolution should be documented through cross-referenced databases and reports to eliminate the possibility of conflicting correction plans and/or duplication of effort.

- a. By October 1, 2008 CIMU will generate a quarterly report to DDD, OOL and SRU that provides trending information through the aggregation of incidents by region, type, investigative assignment and findings.
- b. By July 1, 2009 the Department will create a data field in the UIRMS system that allows for the entry & querying of final actions taken re. the disposition of cases.
- c. By October 1, 2009 CIMU will add to the quarterly report described in a. the information regarding actions taken in response to findings.

Appendix G: Participant Safeguards

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).

N.J.A.C. 10:44A, N.J.A.C. 10:44B and N.J.A.C. 10:44C state that individuals receiving medication shall take their own medication to the extent that it is possible, as assessed and determined by the Interdisciplinary team documented in the individual's Service Plan and in accordance with licensee procedure. Individuals who take their own medication shall receive training and monitoring by the licensee regarding the safekeeping of the medications for the protection of others.

Licensed residential facilities have a manual of written procedures, including procedures for medication administration, self-medication, storage and destruction in accordance with N.J.A.C 10:44A. The procedures must include staff titles and be unambiguous as to authority and responsibility. Each provider agency will perform oversight activities according to their own policies and procedures. Staff of provider agencies who will be administering medication will pass the required eight (8) hour medication training.

Licensed Community Care Residences (CCR) must adhere to the standards in N.J.A.C. 10:44B when administering medications. Community Care Residence providers and their alternates will complete required medication administration training given by the Division of Developmental Disabilities.

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:

Medication errors considered incidents are reported to DDD via a UIR form which is then forwarded to the Department of Human Services utilizing the Unusual Incident Reporting & Management System (UIRMS). Trend analysis and aggregation of data is available through the Critical Incident Management Unit (CIMU) via UIRMS.

(b) Specify the types of medication errors that providers are required to *record*:

Providers are required to record but not report medication documentation errors. Medication documentation errors are usually a result of staff performance issues when proper procedures and documentation failed to be utilized, however the appropriate medication/treatment was administered to the individual. Providers are required to make this information available to the State for review and/or trend analysis.

These errors are documented on the Medication Administration Record and are reviewed by the Case Manager at the regularly scheduled visit. On an annual basis as part of the licensing process, the Developmental Disabilities Licensing Unit conducts a sample audit of medication records as part of the licensing renewal process.

(c) Specify the types of medication errors that providers must *report* to the State:

Medication/Treatment error (MD220)-Any deviation from the prescribed orders that results in serious effects requiring medical intervention. This is considered a reporting level A incident and requires immediate telephone notification to Division administrative personnel.

Medication/Treatment Error (MD210) – Any deviation from prescribed orders that has the potential for serious effects as determined by a qualified medical professional (i.e.-doctor, pharmacist). This is considered a reporting level B incident.

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

- iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

DDD Case managers will visit licensed residential facilities quarterly. Medication administration, documentation and storage will be monitored on a random sample basis, ensuring that each waiver participant's medication regimen is monitored at least twice in a calendar year. Medication administration audits may also be initiated if there are significant changes in an individual's health, behavior or medication regime. Findings are documented on the ALA visit form. Case Managers can refer to Regional nurses for additional assessment, consultation or training.

Case Managers will visit Community Care Residences monthly and assess medication documentation, storage, and record keeping. Technical assistance and hands on training will be given to the CCR provider if necessary. A referral to the Regional nurse will be initiated by the case manager if further assistance, consultation or training is warranted.

For both Licensed Residential Facilities and Community Care Residences: Where case manager monitoring reveals potentially harmful practices or medication management and administration process deviations or errors, a (Quality Activity) form will be completed including follow-up tasks, time frames, and person responsible. This information will be shared with the appropriate supervisors. The case manager will document follow-up actions at the following visit or sooner, if warranted.

N.J.A.C. 10:44A provides that written records of all medication administered be kept, written documentation exists indicating that all medication was re-evaluated at least annually by the prescribing physician, that staff have access to a medication reference book including information on side effects and drug interactions, any medication changes are documented immediately, there shall be no interruption of the medication administration schedule, and that medications shall be stored properly and in their original containers. N.J.A.C. 10:44A also provides for the prescription, administration, documentation and storage of PRN (as needed) medication and over-the counter medications.

DDL inspects licensed Community Care Residences annually. N.J.A.C. 10:44B mandates that providers will receive training, only medication prescribed by a physician will be administered, written records of medication administration be kept, adequate supplies of medications are available, medications are stored properly and safely, and medication errors will be reported to the physician and case manager.

After an inspection by DDL of either a Licensed Residential Facility or a CCR, if deficiencies are noted, a written report will be generated requesting a plan of correction with designated time frames. In the event that there are deficiencies in either type of facility, the case manager will follow up on the deficiencies to ensure compliance with the plan of correction.

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:

The State, on an on-going basis, identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

Interview with consumer, Skill Development Home Program Monthly Report, Provider Agency

Program Monthly Report

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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" 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="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS, DDD	<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 type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Unusual Incidents, Incident Follow up Reports, Agency Files and records, complaints that don't arise to UIR level, Interviews, SRU Investigation Report

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 checked="" 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 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: DHS, OPIA,DDL	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 100% of the agencies authorized under NJAC 10:44A & C are reviewed annually.
	<input checked="" type="checkbox"/> Other Specify: As needed based on incident reporting trends.	

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Unusual Incident Reports, Follow up Reports, Agency and Provider Records. Any additional records and interview.

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 checked="" 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 type="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS,OPIA,SRU	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: As necessary during the course of an investigation.
	<input checked="" type="checkbox"/> Other Specify: As needed based on investigation.	

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Provider Agency Investigative Reports

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" 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: DHS,OPIA,CIMU	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Per investigation.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Unusual Incidents and Follow up Reports

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input checked="" 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 type="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS,OPIA,CIMU	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Per investigation
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

UIR and Follow up Reports, Interviews and Investigations

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 type="checkbox"/> Operating Agency	<input checked="" 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: DHS, Danielle's Law Panel	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Per alleged violation
	<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 checked="" type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHS,DDD; DHS,OPIA,DDL; DHS,OPIA,SRU; DHS,OPIA,CIMU; DHS, Danielle's Law Panel	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Per findings in the investigation of an unusual incident.

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

b. Methods for Remediation/Fixing Individual Problems

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

When an allegation is received, DDD regional staff (including case management) do a risk assessment to determine if the individual is safe in the current environment and make arrangements to relocate the individual if it is deemed necessary.

Investigations are conducted by the Special Response Unit, DDD, and contracted agencies dependent on the type of incident and severity.

The results of the investigation are reported and DDL and/or DDD determine corrective action to address the situation. Corrective action can run the gamut from reporting the incident to law enforcement (this may occur at the time of the initial allegation) through licensing actions such as terminations and suspensions, to recommendations for training.

- 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 checked="" type="checkbox"/> Other Specify: DHS,DDD; DHS,OPIA,CIMU	<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%; margin-top: 5px;"></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 Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The following is as agreed upon with CMS in the NJ Plan of Correction:

The Office of Program Integrity and Accountability (OPIA) has developed a risk management system that will aggregate, analyze, and provide summaries of problem remediation to ensure the health and safety of waiver participants. The following represents an overview of the system designed to achieve a broad proactive approach to identify, and minimize risk to an individual’s health and safety:

- f. The system includes a Quality Indicators Report that is issued quarterly, and includes the following domains: incident reporting, abuse and neglect investigation, inspection and program review, and fiscal integrity.
- g. Each domain has associated indicators of health, safety and welfare.
- h. Data on these indicators is provided by the appropriate OPIA or Division component, to the Critical Incident Management Unit for inclusion in the quality indicators report
- i. Upon receipt of the Quality Indicators Report, the appropriate Unit/Division will conduct a root cause analysis of the data associated with its Unit, and prepare a report of its findings for discussion.
- j. A Council on Systemic Risk comprised of a cross section of Department managers; analyze the data, determine course of action, and institute a timeline for completion of action steps.
- e. Quarterly review of data by the Council will measure the success of the action plan.

f. Improved outcomes for waiver participants will continue to be measured.

Timeframes for implementation are as follows:

d. By June 1, 2008 the Council on Systemic Risk will have its first organizing meeting

e. By June 15, 2008 internal and external stakeholders will have knowledge of the Risk Management System, and the data being analyzed.

f. By July 1, 2008 the Council will have its first quarterly meeting to review data.

- Coordination between the four divisions involved in incident reporting, investigation, and resolution should be documented through cross-referenced databases and reports to eliminate the possibility of conflicting correction plans and/or duplication of effort.

d. By October 1, 2008 CIMU will generate a quarterly report to DDD, OOL and SRU that provides trending information through the aggregation of incidents by region, type, investigative assignment and findings.

e. By July 1, 2009 the Department will create a data field in the UIRMS system that allows for the entry & querying of final actions taken re. the disposition of cases.

f. By October 1, 2009 CIMU will add to the quarterly report described in a. the information regarding actions taken in response to findings.

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.

With regard to the Level of Care assurance NJ is developing an uniform methodology for monthly random sampling and analysis of client reviews for two (2) tiers of oversight at the Case Management Supervisors and Community Care Waiver Monitor levels. The process is projected to be finalized in October of 2008. Quarterly aggregation of trend/analysis reports will begin in January of 2009 when a process will be in place to conduct trend analysis of timeliness and appropriateness of determinations. Remediation will be tracked where issues are identified.

With regard to the assurance that Plans of Care are responsive to Waiver Participant needs. NJ DDD will create a system with a dual tier of oversight. An electronic platform to track two tiers of oversight will be developed by October 1, 2008 to allow the Case Management Supervisors to review monthly a five percent sampling of plans of care. An electronic platform will also be developed to allow the Community Care Waiver Monitor to review 268 cases annually. Quarterly reports aggregating and identifying issue from reviews will be developed by January of 2009. An electronic alert notification process informing the Case Manager (QMRP) and his/her supervisor of plans of care due within 60 days and those that are overdue by 30 days will also be developed in July 2008. This system will allow reviews that will encompass all of the subassurances and permit trending analysis and systemic remediation where necessary.

With regard to Assurance III: "Qualified Providers Serve Waiver Participants" NJ will develop by October of 2008 an electronic platform to allow the Community Care Waiver Monitor to document a review of 268 cases annually. By January 2009 DDD will have developed, at a minimum, quarterly reports that aggregate data by region and identify follow up actions to ensure compliance. In addition by October of 2008, NJ will have an electronic platform to store, analyze, and trend Day Program Review information. A process to distribute Day Program information to the regions will be in place by January 2009.

Over the course of the next three years NJ will work on building a database to track all provider staff information on a master database maintained statewide including hire dates, dates of required trainings, dates trainings were passed. The database is projected to be completed by January of 2011. From this database NJ will produce quarterly reports for the Statewide Training Advisory Committee to analyze and make recommendations regarding remediation.

A direct link for the Family Support Qualified provider database on the DDD home page exists. A hard copy (paper) file of qualified provider is maintained in the Division's Central Office.

With regard to the "Health and Welfare of Waiver Participants" assurance NJ developed a risk management system that will aggregate, analyze, and provide summaries of problem remediation to ensure the health and safety of waiver participants. The system includes a Quality Indicators Report that is issued quarterly, and includes the following domains: incident reporting, abuse and neglect investigation, inspection and program review, and fiscal integrity. A Council on Systemic Risk comprised of a cross section of Department managers analyzes the data, determines course of action, and institutes a timeline for completion of action steps. Quarterly review of data by the Council will measure the success of the action plan.

By October 2008 a quarterly report will provide trending information through the aggregation of incidents by region, type, investigative assignment and findings for all associated Divisions.

By October 2009 a quarterly report will described the information regarding actions taken in response to findings.

Assurance V: requires that "State Medicaid Agency Retains Administrative Authority over the Waiver Program".

The Quality Management Unit (QMU) of DMAHS (the designee for the Single State Medicaid Agency), will provide ongoing evaluation and documentation of CMS quality assurance measures through a system of annual comprehensive desk audits, interim targeted desk audits, interim targeted on-site audits, topic audits, and participation in the DDD quality assurance meetings and Interagency meetings. In May 2008 the QMU began conducting annual comprehensive desk audits covering the level of care need determinations, the responsiveness of Plans of Care to participant needs, the assurance that individuals receive services from qualified providers, the assurance that health and welfare of waiver participants are addressed, and the assurance that there is appropriate fiscal accountability for payment related to services rendered. Upon completion of any audit, QMU will prepare a written audit report which will be sent to the audited agency within 60 days summarizing general findings, any identified areas requiring remediation as well as agency strengths.

System Improvement Activities

Responsible Party (<i>check each that applies</i>):	Frequency of Monitoring 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 checked="" 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 checked="" type="checkbox"/> Other Specify: DHS,DDD; DHS,OPIA,DDL & CIMU &SRU; DHS,DMAHS	<input type="checkbox"/> Other Specify: <input type="text"/>

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.

As previously stated, the Division has a Policy and Procedure Committee that meets every two weeks to review needed systemic changes to current policies/regulations. Stakeholders are included on the committee. Changes of a substantive nature are circulated to stakeholders for comment and distribution. Changes in regulation are published in the NJ Register and open for a comment period. The Division must respond to the comments prior to finalizing the regulation. All changes in Division Circulars are forwarded to service providers and constituency groups.

The Assistant Commissioner on a monthly basis meets with a constituency group "Dialogue with the Division" to discuss issues, remediation activities and identify issues, concerns, and/or successes.

Activities to facilitate individuals' placement into the community from institutional placements are discussed in no less than biweekly meetings. Constituency groups are updated at meetings such as the Dialogue with the Division and feedback is generated at that time.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

In 2004 DDD established the Quality Management Steering Committee (QMSC) to advise, support and assist in the design and implementation of the DDD quality management system. This QMSC is comprised of families, individuals, advocates and other stakeholders who meet quarterly to assess the effectiveness of the quality management system. They review DDD information and data collection strategies, and discuss necessary and appropriate strategy modifications. Regional Continuous Quality Improvement Committees (RCQI) comprised of families, individuals, advocates, DDD staff and other stakeholders assist the QMSC by providing support to the Regions to implement and monitor the strategies recommended by the QMSC to address all assurances. To close the loop, RCQI committees provide information back to the QMSC.

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).

Independent audit of provider agencies on an annual basis is a requirement for agencies operating under contract with the Single State Medicaid Agency (DHS). This requirement is delineated in the State Contract Manual in The Department of Human Services' Policy Circular P2.01. Specifically section 3.09 of this policy requires an annual audit that is agency wide in scope. The audit must be conducted in accordance with the Federal Single Audit Act of 1984, generally accepted auditing standards as specified in the Statements of Auditing Standards issued by the American Institute of Certified Public Accountants (AICPA) and Government Auditing Standards issued by the Comptroller General of the United States. In addition the policy stipulates that at any time an agency may be audited by the Department of Human Services (DHS), the Single State Medicaid Agency, or any other appropriate unit of the state or federal government and/or by a private firm approved by the DHS. In addition, agencies providing Individual Support services in residential settings for Traumatic Brain Injury (TBI) are required by state regulation N.J.A.C. 10:44C to have an agency wide audit conducted

annually. DHS does not dictate the auditing corporation selected by a provider agency but rather ensures compliance re. scope and standards for the annual audit. A more detailed explanation of the mandatory audit requirements are documented in DHS Policy Circular P7.06.

Provider billing is done by UNISYS, a corporation under contract with the Division of Medical Assistance and Health Services (DMAHS), the component of the DHS designated with oversight of HCBS waivers. UNISYS is audited annually according to the SAS 70 auditing standard of the AICPA. The audit evaluates systems control design process, key controls that support control objectives, effectiveness of the control design, and any control gaps which would indicate a risk factor. The SAS 70 auditing standard also comports with CMS focus on quality in that in addition to an audit of controls the system also provides for an evaluation of the operating effectiveness of specified controls over a specified time period (generally six (6) months). The audit is bid by RFP. Currently the auditing agency is Ernst & Young, LLP. The specific policies and procedures for the UNISYS audit are available through the State Medicaid agency.

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:

State financial oversight exists to assure that claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Online attendance records and expenditure reports.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" 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="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS,DDD	<input checked="" 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: DDD Fiscal-Ad Hoc (based on unusual rates more than twice or less than half of rate. DDD, Annual or as necessary.	
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Data Source (Select one):
 Record reviews, on-site
 If 'Other' is selected, specify:
 Provider and consumer records and files.

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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" 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 style="width: 100%;" type="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS,DDD	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: The Regional : The Regional Monitor will review 24 cases on a random basis in a region each month rotating regions so that each region is reviewed 3 times within the year.
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

Data Source (Select one):
 Financial audits
 If 'Other' is selected, specify:
 Cost Report Rates

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 checked="" 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 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 style="width: 100%;" type="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS,DDD	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

	<input checked="" type="checkbox"/> Other Specify: At the time of rate adjustments.	
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Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
Unusual Incident Reports (UIR)

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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" 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: DHS,DDD	<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 type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):
Financial audits
If 'Other' is selected, specify:
Provider fiscal records

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 checked="" 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 type="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS, Office of Audit(OOA)	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Five per year
	<input checked="" type="checkbox"/> Other Specify: As necessary	

Data Source (Select one):
Financial audits
If 'Other' is selected, specify:
OOA contract audit findings.

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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 checked="" 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 type="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS,DDD	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Contract audit findings are factored/included into final rate calculations.
	<input checked="" type="checkbox"/> Other Specify: When rates are updated.	

Data Source (Select one):

Financial audits

If 'Other' is selected, specify:

DDD/DHS final reports of expenditure (ROE). Single audit by a licensed accounting firm.

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 checked="" 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: DHS,DDD	<input checked="" 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 type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Provider attendance and ROE.

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 checked="" 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: DHS,DDD	<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: Ad Hoc	

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

DDD eligibility files (one component of the claim file) and DMAHS eligibility files.

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 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: DHS,DDD	<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: DDD Fiscal - Ad Hoc	

Data Source (Select one):

Financial audits

If 'Other' is selected, specify:

Consumer Information System; Waiver Eligibility File; Consumer Service Recording

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 checked="" type="checkbox"/> 100% Review
<input 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="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS,DDD	<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 type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

HIPPA 837-P, DDD claim 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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input 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="text"/>
<input checked="" type="checkbox"/> Other Specify: DHS, UNISYS (Fiscal Agent for the Medicaid system)	<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 type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

HIPPA 837-p, Program records, DDD and DMAHS consumer eligibility records

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 checked="" 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: DHS,DDD	<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 <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 checked="" type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHS,DDD; DHS,OOA; DHS,UNISYS(Fiscal Agent for the Medicaid system)	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: DDD Fiscal - Ad Hoc (based on unusual rates more than twice or less than half of rate. DDD, Annual or as necessary. At the time of rate adjustments.

- 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. DDD Fiscal Department requires the executive director of provider agencies to monitor the accuracy of attendance records and expenditure reports and to certify that they are accurate on a monthly basis.

DDD staff on an ongoing basis review provider and DDD case files records to insure that individuals receiving waiver services are in need of the services, maintains eligibility, and receive the services as documented in their individual service plans. Many of these checks are accomplished monthly and/or quarterly through case management on site visits and again annually at the time of the service plan meeting.

DDD reviews to ensure that federal claim rates have been appropriately calculated by analyzing cost reports submitted by provider agencies. High and low rates that are at a deviance of 50% or 200% of the mean are reviewed and justified during the process of setting cost rates.

On a monthly basis DDD reviews Unusual Incident Reports of deaths to ensure that the service claims ceased on the date of death.

DHS conducts five audits for select agencies that provide services for the Division of Developmental Disabilities as an additional line of oversight beyond the required annual independent audit. The audit findings are reviewed when calculating final Community Care Waiver (CCW) rates.

Required single audit (section P7.06 of the Contract Policy Manual) performed in accordance with federal OMB circular A-133 and Department policy by a licensed accounting firm on an annual basis, ascertain that the financial statements fairly represent the financial position of the organization including a review of the DDD/DHS final Report of Expenditures (ROE) as mandated by section P2.01 of the Contract Policy Manual.

Posted provider attendance and reports of expenditure (ROE) data in the DDD systems are reviewed by DDD to correct potential errors and omissions.

By matching on an ad hoc basis DDD eligibility files with the DMAHS eligibility files, apparent discrepancies are discovered and resolved.

Review of billing factors is done to ensure eligibility which results in the generation of a pre-claim report to finalize billing.

Billing reports are screened by the fiscal agent for the Medicaid System through exception edits that remove contradictory or unauthorized claims which are then reported to DDD for follow up.

Denied claims are reviewed by DDD to determine errors and make corrections where possible.

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.

DDD Fiscal Department requires the executive director of provider agencies to monitor the accuracy of attendance records and expenditure reports and to certify that they are accurate on a monthly basis. DDD identifies when an attendance record has not been certified and will not process until the executive director has done so.

DDD staff on an ongoing basis review provider and DDD case files records to insure that individuals receiving waiver services are in need of the services, maintains eligibility, and receive the services as documented in their individual service plans. Many of these checks are accomplished monthly and/or quarterly through case management on site visits and again annually at the time of the service plan meeting. Plans of care are adjusted if necessary, reports are generated to appropriate parties (e.g. contract administrators, the Developmental Disabilities Licensing, etc.) unusual incidents are generated.

DDD reviews to ensure that federal claim rates have been appropriately calculated by analyzing cost reports submitted by provider agencies. High and low rates that are at a deviance of 50% or 200% of the mean are reviewed and justified or addressed during the process of setting cost rates.

On a monthly basis DDD reviews Unusual Incident Reports of deaths to ensure that the service claims ceased on the date of death. Where incidents of service claims continued the issue is investigated and resolved.

DHS conducts five audits for select agencies that provide services for the Division of Developmental Disabilities as an additional line of oversight beyond the required annual independent audit. The audit findings are reviewed when calculating final Community Care Waiver (CCW) rates.

Required single audit (section P7.06 of the Contract Policy Manual) performed in accordance with federal OMB circular A-133 and Department policy by a licensed accounting firm on an annual basis, ascertain that the financial statements fairly represent the financial position of the organization including a review of the DDD/DHS final Report of Expenditures (ROE) as mandated by section P2.01 of the Contract Policy Manual. Issues are addressed by DDD contract administrators with the agencies involved.

Posted provider attendance and reports of expenditure (ROE) data in the DDD systems are reviewed by DDD to correct potential errors and omissions.

By matching on an ad hoc basis DDD eligibility files with the DMAHS eligibility files, apparent discrepancies are discovered and resolved. DDD IT and Fiscal staff then work to correct the issue(s). These issues often mean correcting addresses and/or middle initials.

Billing reports are screened by the fiscal agent for the Medicaid System through exception edits that remove contradictory or unauthorized claims which are then reported to DDD for follow up. DDD then reviews and reconciles the denied claims to determine errors and make corrections where possible.

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 checked="" type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DHS,DDD	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 15px;" 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 Financial Accountability 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 I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Division of Developmental Disabilities (DDD), the component of the DHS charged with the daily administration of the waiver, contracts with various non-profit and proprietary organizations who meet the specified HCBS standards to render specific waiver services. Contract reimbursement is determined via two contracting manuals developed and promulgated by the Single State Medicaid Agency, the Department of Human Services (DHS). These contract manuals are the "Contract Reimbursement Manual" and "Contract Policy and Information Manual".

Eligible contract expenditures are utilized as the basis for determining Medicaid reimbursable cost rates. The DDD prepares a cost report for each type of service funded under a cost reimbursement contract. The Office of Finance, Bureau of Rate Setting performs a detailed desk review of the cost reports. The Bureau of Rate Setting then develops and recommends Medicaid rates for approval by the Director of the Division of Medical Assistance and Health Services the DHS designee for HCBS oversight. Based on the most current actual historical costs of the various contracted service providers Interim Medicaid Billing Rates are developed. These rates are computed by applying an inflationary increment. The CCW cost reimbursement rate setting methodology calls for the use of an "appropriate inflationary increment". Since the interim rates are adjusted to final rates based on actual costs and units of service the inflationary increment is only important for cash flow purposes during the billing period. Currently New Jersey uses the Cost of Living Adjustment (COLA) percentage applied to base year rates as the inflationary increment. The average COLA for FY06, FY07 and FY08 is 1.17%. We believe that this is a more accurate indicator of actual costs for the billing period than the use of a CPI based factor.

The Department provides information regarding the rate determination methods upon request from the public. In addition, the federal cost of waiver services is identified annually in the State budget.

When actual costs for the fiscal year become available Final Cost reports are prepared by DDD to determine the actual Medicaid reimbursable costs based on the State fiscal year ending June 30th.

Cost Reports are based on the contracted service providers' actual reported expenditures. Total allowable costs are determined excluding any costs that are unavailable for federal reimbursement such as Room and Board for Individual Support services. Attendance records provided by the contracted service providers are the source for determining the total units of service and Medicaid eligible units provided. The unit cost of each service is determined by dividing total allowable costs by the total units of service rendered to both Medicaid and non-Medicaid eligible individuals. The unit cost is multiplied by the number of Medicaid eligible units of service to compute the Medicaid reimbursable costs for each contracted service provider. Upon approval of the final rates by the Director of the Division of Medical Assistance and Health Services the approved amounts are claimed for Federal reimbursement on the Quarterly Statement of Expenditure by the Division of Medical Assistance and Health Services. Currently, staff have been aggressively working to update the Community Care Waiver final rates for previous years while at the same time creating an Information Technology (IT) System that will facilitate the development of final rates in a timelier manner.

Consumers who participate in the self-directed option are informed of the maximum rates for generic services available under the waiver at the time of enrollment onto the waiver. At this time, rates for all other waiver services are not published since the department contracts with providers using interim rates; final rates are established only after cost reports of the providers are examined and are available upon request. As we move to a fee for service payment system, the maximum rates for waiver services will be published in advance.

- 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:

Service providers are paid via contract with the Division for providing services at a specified level of service (LOS). Providers submit monthly attendance sheets to DDD identifying the dates on which a HCBS waiver eligible individual received a HCBS waiver service and the number of units of service received. These monthly attendance records are submitted electronically via a secure website or in hard copy through the mail. Attendance records currently submitted electronically include Individual Supports, Respite (both hourly and daily), Day Habilitation and Supported Employment. At this point 143 Provider Agencies submit information online, an

additional 36 Provider Agencies are registered for electronic submission but do not utilize the service and 93 smaller Provider Agencies have not yet registered. As previously mentioned those agencies that do not submit attendance data electronically do so via hard copy in the mail.

Billing is then consolidated electronically by DDD staff (who input those attendance records that are submitted in hard copy) and submitted to UNISYS, the Medicaid contracted billing entity. UNISYS conducts an initial audit against duplicate claims, waiver eligibility, accurate service codes, etc. The billing is then forwarded to CMS for payment less any billing that has been excluded and noted for follow up.

Billing that UNISYS has identified for follow up is returned to the DDD via computer disc. The DDD Information Technology staff then reconciles the billing. Inaccurate codes are corrected, conflicts in billing are addressed and a reconciled billing is forwarded to UNISYS for review. If the reconciled billing satisfies the UNISYS audit upon review it is forwarded to CMS for billing.

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:

There are duplicate checks and balances to assure that claims are made only for individuals eligible for Medicaid waiver payment by providers of services that meet the required waiver standard on the date the service was rendered. DDD, the component of DHS charged with the daily administration of the CCW does an initial screening through its Management Information System to ensure eligibility of both the individual and the service prior to submitting the billing to UNISYS. UNISYS also has edits that prevent billing for individuals that are not eligible on the date of service delivery.

With regard to service provision, DDD requires attendance records from the contracted entities prior to billing for services. There are a number of internal checks to ensure that each waiver service was rendered including case management visits, logs maintained at the

residence and in the day program, reports submitted to the Division by the service provider etc.

At the time of the annual service plan the interdisciplinary team is required to include all services the individual will require or utilize within the upcoming year in Division Circular #35. A random representative sample audit performed by Division staff on a quarterly basis in each region examines the service plan to ensure that the services for which DDD receives federal reimbursement are included in the service plan.

- 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:

- 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.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

- e. **Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

- f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. **Additional Payment Arrangements**

- i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

- ii. **Organized Health Care Delivery System.** *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

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:

DDD the component of the Single State Medicaid Agency charged with day to day administration of the waiver receives the funds appropriated annually by the NJ State Legislature and Executive Branch from the State Treasury and reimburses via contracts the subcontracting entity that directly provides the waiver services. The Operating Agency then bills the State Medicaid Agency through the billing contracted entity UNISYS for waiver services rendered.

- 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:

With regard to Community Care Residence licensed under NJAC 10:44B, the service provider is paid for individual supports separate from room and board. Only the payment for individual supports is calculated into the waiver reimbursement rates.

With regard to residences licensed under NJAC 10:44A & 10:44C, an algorithm was developed to exclude room and board costs from billing. This algorithm deducts from the total contracted cost the costs for materials, facilities, specific assistance line items (clothing, etc.), general equipment, and 40% of profit (where the agency is operating as a “for profit” agency).

Respite Services may be furnished in other residential settings. Room and Board is not excluded for Respite Services offered out of the individual’s own home except in a private residence. In those cases the Division pays for Room and Board separately and does not include that amount in the cost rate for respite services.

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:

The Room and Board expenses for an unrelated live-in caregiver are determined to be equal, on the average, to one-half the cost of room and board paid by the recipient of services. We estimate that the average annual cost of room and board per recipient is \$19,920. Therefore, the estimated average cost per a live-in caregiver is \$9,960 per year. Only the cost for rent and food for an unrelated live-in personal caregiver are reimbursed. The room and board expense is funded by the Division therefore the participant is not reimbursed.

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: ICF/MR

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	53526.95	11507.00	65033.95	231533.00	7226.00	238759.00	173725.05
2	54628.00	13694.00	68322.00	259317.00	8454.00	267771.00	199449.00
3	55692.39	16295.00	71987.39	290435.00	9892.00	300327.00	228339.61

4	56519.29	19392.00	75911.29	325287.00	11573.00	336860.00	260948.71
5	57637.44	23076.00	80713.44	364322.00	13541.00	377863.00	297149.56

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:	
		ICF/MR	
Year 1	11571		11571
Year 2	12265		12265
Year 3	13001		13001
Year 4 (renewal only)	13781		13781
Year 5 (renewal only)	14608		14608

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 was calculated by taking the mean of the average length of stay as recorded in HCFA 372 lag reports for 10-1-04 through 9-30-05, 10-1-05 through 9-30-06, and the 372 initial report for 10-1-05 through 9-30-06 and 10-1-06 through 9-30-07.

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:

Data from the previous Renewal was compared to actual usage and found to be an accurate predictor off cost and usage. Factor D from the fifth year of the proposed amendment submitted in December of 2007 was used as the base. Actual consumers at a single snapshot in the year was reviewed against actual usage. That number 10,450 was reduced to a base of 10,250. The 200 differential was subtracted from the anticipated final waiver year of 11,126 leaving 10,916 as the base. An increase of .06 was factored against this number to derive anticipated unduplicated participant count on an annual basis.

The prior # of users per service was adjusted by .03% from the amendment application based upon the anticipated increase in users of 6% against the decrease of slots for the proposed base. 6% increase was then factored against the number of users in each service area on an annual basis.

Average cost/unit was factored against a Cost of Living Allowance (COLA) of 1.8% annually based upon a five (5) year history. Average units per user was maintained at a flat level for the five (5) year period. The calculations for Assistive Technology Devices was calculated full use to a limit of \$3,667 annually. Similar calculation were utilized for Assistive Technology Devices.

Transition Services were estimated for the number of individuals entering the waiver from Developmental Centers on an annual basis. The total unit cost includes all of the potential services that can be utilized under the CMS definition of Transition Services.

The calculations for non medical transportation were based upon the percentage of individuals self directing who demonstrate higher service needs and therefore would require the more costly agency transportation services. The costs for agency transportation factor in a driver. The cost for "regular" non medical transportation assumes the provider of individual supports is also the driver of the vehicle and therefore is calculated at the state standard of \$0.31 per mile.

The initial cost for case management was set against an adjusted rate that factored out individuals in a "case management" title who do not perform actual case management work. The annual increase was set against a 1.8% annualized estimated COLA.

- 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:

Factor D' was calculated based on the history in the HCFA 372 reports. A base rate of \$8126 was utilized from year 2006 lag report where the full impact of Medicare D registered. The average percentage increase from the 2003, 2004 and 2005 lag report was 19%. This increase was applied to the base rate for 2007 and 2008 to compute the base D' to begin this five year cycle.

Factor D' was calculated based on the history in the HCFA 372 reports. A base rate of \$8126 was utilized from year 2006 lag report where the full impact of Medicare D registered. The average percentage increase from the 2003, 2004 and 2005 lag report was 19%. This increase was applied to the base rate for 2007 and 2008 to compute the base D' to begin this five year cycle.

- 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:

This estimate was taken from expenditure data for the previous five years. The initial base of \$184,577 for the 2006 lag period was utilized with a 12% annual increase based upon historical trends in this area. This number was utilized due to a fluctuation in actual historical data that indicated the annual percentage increase had dropped to 12%. The assumption is that the ongoing increase will stabilize at 12%.

- 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:

Factor G' was calculated based on the history in the HCFA 372 reports. A base rate of \$5,279 was utilized from year 2006 lag report when the full impact of Medicare D registered. The average percentage increase from expenditure data for the three years prior was 17. This increase was applied to the base rate going forward with 2007 and 2008 to compute the final G' for the 2008 five year projected estimates.

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
Transportation
Respite
Community Transition Services
Case Management
Day Habilitation
Individual Supports
Environmental and Vehicle Adaptations
Assistive Technology Devices
Support Coordination
Supported Employment
Personal Emergency Response System (PERS)

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Total:						7258467.60
Transportation (Non Medical)	Mile	428	3000.00	0.32	410880.00	
Transportation (Non Medical) agency	Mile	644	2010.00	5.29	6847587.60	
Respite Total:						6689502.64
a. Respite	Hour	2357	28.00	19.34	1276362.64	
b. Respite	Day	3660	17.00	87.00	5413140.00	
Community Transition Services Total:						1272500.00
Community Transition Services	Year	125	1.00	10180.00	1272500.00	
Case Management Total:						21548441.88
Case Management	Month	11571	12.00	155.19	21548441.88	
Day Habilitation Total:						164098667.84
a. Day Habilitation	Day	6796	216.00	94.69	138998859.84	
b. Day Habilitation	Hour	1072	1150.00	20.36	25099808.00	
Individual Supports Total:						407281998.00
a. Individual Supports	Day	8537	336.00	139.00	398712048.00	
b. Individual Supports	Hour	970	465.00	19.00	8569950.00	
Environmental and Vehicle Adaptations Total:						2181865.00
Environmental and Vehicle Adaptations	Year	595	1.00	3667.00	2181865.00	
Assistive Technology Devices Total:						2181865.00
Assistive Technology Devices	Year	595	1.00	3667.00	2181865.00	
Support Coordination Total:						2186880.00
Support Coordination	Month	1072	12.00	170.00	2186880.00	
Supported Employment Total:						4423876.00
Supported Employment	Hour	971	67.00	68.00	4423876.00	
Personal Emergency Response System (PERS) Total:						236286.96
PERS	Month	403	12.00	48.86	236286.96	

GRAND TOTAL:**619360350.92****Total Estimated Unduplicated Participants:****11571****Factor D (Divide total by number of participants):****53526.95**

Average Length of Stay on the Waiver:

355

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	Component Cost	Total Cost
Transportation Total:						7835393.70
Transportation (Non Medical)	Mile	454	3000.00	0.32	435840.00	
Transportation (Non Medical) agency	Mile	683	2010.00	5.39	7399553.70	
Respite Total:						7219934.16
a. Respite	Hour	2498	28.00	19.69	1377197.36	
b. Respite	Day	3880	17.00	88.58	5842736.80	
Community Transition Services Total:						1295375.00
Community Transition Services	Year	125	1.00	10363.00	1295375.00	
Case Management Total:						23251496.40
Case Management	Month	12265	12.00	157.98	23251496.40	
Day Habilitation Total:						177086241.60
a. Day Habilitation	Day	7204	216.00	96.40	150004569.60	
b. Day Habilitation	Hour	1136	1150.00	20.73	27081672.00	
Individual Supports Total:						441306288.00
a. Individual Supports	Day	9049	336.00	142.00	431745888.00	
b. Individual Supports	Hour	1028	465.00	20.00	9560400.00	
Environmental and Vehicle Adaptations Total:						2313877.00
Environmental and Vehicle Adaptations	Year	631	1.00	3667.00	2313877.00	
Assistive Technology Devices Total:						2313877.00
Assistive Technology Devices	Year	631	1.00	3667.00	2313877.00	
Support Coordination Total:						2359153.92
Support Coordination	Month	1136	12.00	173.06	2359153.92	
Supported Employment Total:						4772234.46
Supported Employment	Hour				4772234.46	

		1029	67.00	69.22		
Personal Emergency Response System (PERS) Total:						254867.76
PERS	Month	427	12.00	49.74	254867.76	
GRAND TOTAL:					670008739.00	
Total Estimated Unduplicated Participants:					12265	
Factor D (Divide total by number of participants):					54628.00	
Average Length of Stay on the Waiver:					355	

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	Component Cost	Total Cost
Transportation Total:						8450905.20
Transportation (Non Medical)	Mile	481	3000.00	0.33	476190.00	
Transportation (Non Medical) agency	Mile	724	2010.00	5.48	7974715.20	
Respite Total:						7789788.48
a. Respite	Hour	2648	28.00	20.04	1485845.76	
b. Respite	Day	4112	17.00	90.18	6303942.72	
Community Transition Services Total:						1318750.00
Community Transition Services	Year	125	1.00	10550.00	1318750.00	
Case Management Total:						25091409.96
Case Management	Month	13001	12.00	160.83	25091409.96	
Day Habilitation Total:						191068326.88
a. Day Habilitation	Day	7636	216.00	98.13	161853266.88	
b. Day Habilitation	Hour	1204	1150.00	21.10	29215060.00	
Individual Supports Total:						477459240.00
a. Individual Supports	Day	9592	336.00	145.00	467322240.00	
b. Individual Supports	Hour	1090	465.00	20.00	10137000.00	
Environmental and Vehicle Adaptations Total:						2453223.00
Environmental and Vehicle Adaptations	Year	669	1.00	3667.00	2453223.00	

Assistive Technology Devices Total:						2453223.00
Assistive Technology Devices	Year	669	1.00	3667.00	2453223.00	
Support Coordination Total:						2545448.64
Support Coordination	Month	1204	12.00	176.18	2545448.64	
Supported Employment Total:						5151145.59
Supported Employment	Hour	1091	67.00	70.47	5151145.59	
Personal Emergency Response System (PERS) Total:						275279.04
PERS	Month	453	12.00	50.64	275279.04	
GRAND TOTAL:					724056739.79	
Total Estimated Unduplicated Participants:					13001	
Factor D (Divide total by number of participants):					55692.39	
Average Length of Stay on the Waiver:					<input type="text" value="355"/>	

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 (renewal only)

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Total:						9107418.60
Transportation (Non Medical)	Mile	510	3000.00	0.33	504900.00	
Transportation (Non Medical) agency	Mile	767	2010.00	5.58	8602518.60	
Respite Total:						8406799.76
a. Respite	Hour	2807	28.00	20.41	1604144.36	
b. Respite	Day	4359	17.00	91.80	6802655.40	
Community Transition Services Total:						1342500.00
Community Transition Services	Year	125	1.00	10740.00	1342500.00	
Case Management Total:						27074703.84
Case Management	Month	13781	12.00	163.72	27074703.84	
Day Habilitation Total:						206200023.60
a. Day Habilitation	Day	8094	216.00	99.90	174655569.60	
b. Day Habilitation	Hour	1277	1150.00	21.48	31544454.00	

Individual Supports Total:						512959356.00
a. Individual Supports	Day	10168	336.00	147.00	502217856.00	
b. Individual Supports	Hour	1155	465.00	20.00	10741500.00	
Environmental and Vehicle Adaptations Total:						2599903.00
Environmental and Vehicle Adaptations	Year	709	1.00	3667.00	2599903.00	
Assistive Technology Devices Total:						2599903.00
Assistive Technology Devices	Year	709	1.00	3667.00	2599903.00	
Support Coordination Total:						2748359.40
Support Coordination	Month	1277	12.00	179.35	2748359.40	
Supported Employment Total:						5556406.48
Supported Employment	Hour	1156	67.00	71.74	5556406.48	
Personal Emergency Response System (PERS) Total:						296928.00
PERS	Month	480	12.00	51.55	296928.00	
GRAND TOTAL:						778892301.68
Total Estimated Unduplicated Participants:						13781
Factor D (Divide total by number of participants):						56519.29
Average Length of Stay on the Waiver:						355

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 (renewal only)

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Total:						9832658.40
Transportation (Non Medical)	Mile	540	3000.00	0.34	550800.00	
Transportation (Non Medical) agency	Mile	813	2010.00	5.68	9281858.40	
Respite Total:						9072659.78
a. Respite	Hour	2976	28.00	20.77	1730722.56	
b. Respite	Day	4621	17.00	93.46	7341937.22	
Community Transition Services Total:						1366625.00
Community Transition Services	Year	125	1.00	10933.00	1366625.00	

Case Management Total:						29216584.32
Case Management	Month	14608	12.00	166.67	29216584.32	
Day Habilitation Total:						222507202.50
a. Day Habilitation	Day	8580	216.00	101.70	188478576.00	
b. Day Habilitation	Hour	1353	1150.00	21.87	34028626.50	
Individual Supports Total:						555173325.00
a. Individual Supports	Day	10778	336.00	150.00	543211200.00	
b. Individual Supports	Hour	1225	465.00	21.00	11962125.00	
Environmental and Vehicle Adaptations Total:						2757584.00
Environmental and Vehicle Adaptations	Year	752	1.00	3667.00	2757584.00	
Assistive Technology Devices Total:						2757584.00
Assistive Technology Devices	Year	752	1.00	3667.00	2757584.00	
Support Coordination Total:						2964206.52
Support Coordination	Month	1353	12.00	182.57	2964206.52	
Supported Employment Total:						5998830.26
Supported Employment	Hour	1226	67.00	73.03	5998830.26	
Personal Emergency Response System (PERS) Total:						320486.76
PERS	Month	509	12.00	52.47	320486.76	
GRAND TOTAL:						841967746.54
Total Estimated Unduplicated Participants:						14608
Factor D (Divide total by number of participants):						57637.44
Average Length of Stay on the Waiver:						355