

# 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 section 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.

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

### 1. Request Information (1 of 3)

- A. The **State of Guam** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of section 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):

Kumunidât Diniseha: Community of Hope

C. **Type of Request:** new

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

- 3 years
- 5 years

**New to replace waiver**

Replacing Waiver Number:

[Empty input box]

**Base Waiver Number:**

[Empty input box]

**Amendment Number**

(if applicable):

[Empty input box]

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

[Empty input box]

**Draft ID:** GU.001.00.00

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

Regular Waiver

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

11/1/26

### PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so

that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**1. Request Information (2 of 3)**

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**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 Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

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

**1. Request Information (3 of 3)**

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**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 section 1915(a)(1)(a) of the Act and described in Appendix I**

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

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

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

**section 1915(b)(1) (mandated enrollment to managed care)**

**section 1915(b)(2) (central broker)**

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

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

**A program operated under section 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 section 1915(i) of the Act.**

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

**A program authorized under section 1115 of the Act.**

*Specify the program:*

**H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

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

**2. Brief Waiver Description**

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**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.

Guam, like many other states and territories, faces a critical challenge of hospital overcrowding driven by limited community-based services and supports. This waiver seeks to transform Guam's long-term care system by shifting from an institutional model to a home and community-based approach under Section 1915(c) waiver authority. The primary goal is to reduce reliance on costly hospital and skilled nursing facility care by creating sustainable alternatives that allow older adults and adults with disabilities to live in their communities of choice with dignity and independence. Guam's Department of Health and Social Services (DPHSS) will operate the 1915(c) Medicaid program in partnership with internal and external stakeholders.

**Goals and Objectives:** The Kumunidat Diniseha: Community of Hope waiver will seek to address both current severe hospital compression and minimize future hospital compression by transitioning individuals who currently reside in hospitals or skilled nursing facilities—and those at imminent risk of unnecessary institutionalization—into community-based settings. Through person-centered care plans, participants will be provided with the opportunity to reconnect with their homes, families, and communities. This initiative is transformational for Guam, as it introduces Medicaid-funded HCBS on the island for the first time, enabling cost savings from reduced institutional care to be reinvested in expanding access to assisted living and other community-based services and supports.

**Population:** The target population includes vulnerable individuals occupying hospital beds due to lack of alternative services and supports, residents of skilled nursing facilities or other institutional settings, and adults who meet hospital or nursing facility level of care (LOC) criteria and are at-risk for unnecessary long-term hospital stays in the absence of HCBS. These individuals will be identified for prioritization into the waiver through existing collaborative discharging planning processes and standardized screening tools. Eligibility determination will be performed by trained and qualified DPHSS staff and will be established based on findings from a standardized functional assessment of need.

**Eligibility and Oversight:** Eligibility will be based on assessed need for institutional-level care in the absence of waiver services and supports. Final authority for eligibility determination and program enrollment will reside with DPHSS, ensuring strong organizational oversight. Partner agencies delivering services will use person-centered practices to identify individuals who may be eligible for and benefit from enrollment in the Kumunidat Diniseha: Community of Hope program and assist those individuals in accessing the waiver, including screening and referrals. DPHSS has dedicated full-time staff for waiver implementation, program operations management, and quality oversight. DPHSS will also leverage its longstanding partnerships with advocacy organizations to monitor operations and adherence to quality standards.

**Services Covered:** Environmental and transitional supports (household setup, deep cleaning), residential support services, home-based support services, person-centered case management, respite, adult day services, non-medical transportation, physical, occupational, and speech therapies, arts therapies, adult day services, home and vehicle modifications, adaptive aids, and nursing services.

**Providers:** Medicaid-enrolled providers including, but not limited to, direct care support staff, paid family caregivers, licensed nurses (LPNs/RNs), certified nurse assistants (CNAs), licensed specialized therapy providers, case managers, and other qualified provider staff. All services will be delivered as defined within the waiver application and in accordance with provider qualification requirements and quality standards.

### 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

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**A. Comparability.** The state requests a waiver of the requirements contained in section 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 section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

- Not Applicable
- No
- Yes

**C. Statewide.** Indicate whether the state requests a waiver of the statewide requirements in section 1902(a)(1) of the Act (*select one*):

- No
- Yes

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

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

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

#### 5. Assurances

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

**A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of

persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

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

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

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

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

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

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

## 6. Additional Requirements

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*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 inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR § 441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR § 431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of section 1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR Part 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. 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 Part 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:

Guam’s Medicaid agency, DPHSS, collected public comment for the 1915(c) Medicaid waiver application in the same manner that public input is solicited on the development of new Medicaid programs and program revisions. DPHSS collects public input through multiple modalities, including public hearings, community outreach, and feedback channels, to develop and administer its programs. This process ensures Guam’s Medicaid programs are informed by and aligned with community needs. The following are examples of tools and processes used to gather public input:

- **Public Hearings:** These allow community members to provide verbal testimony and share their experiences and concerns regarding health and social services.
- **Community Outreach:** DPHSS conducts outreach to reach residents in various parts of Guam, providing opportunities for feedback through smaller, localized events and gatherings.
- **Feedback Channels:** The agency uses other methods for collecting feedback, such as public comment periods for new policies and programs, and direct feedback through phone calls or emails to DPHSS divisions.
- **Accessibility:** DPHSS ensures accessibility at its facilities for people with disabilities, enabling participation in public input sessions and access to services. This includes wheelchair-accessible entrances, parking, and restrooms.
- **Program Development:** Input is used by the DPHSS Director, management, and staff to develop and/or modify programs that are responsive to changing community needs, helping to ensure they are effective and equitable.

In addition to standard methods for soliciting public input, DPHSS conducted a series of both in-person and virtual stakeholder engagement sessions beginning in September 2025 through publication of the waiver application for public comment in mid-June 2026. These stakeholder engagement sessions allowed DPHSS to gain input and insight directly from internal and external partners in the development of the Kumunidât Diniseha: Community of Hope program.

The waiver application was posted for public comment on June 15, 2026 through July 15, 2026.

**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)

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

Last Name:

Taitano

First Name:

John

Title:

Operations Director

Agency:

Department of Health and Social Services

Address:

761 S. Marine Corps Drive

Address 2:

Suite C 2

City:

Tamuning

State: Guam

Zip: 96913

Phone: [ ] Ext: [ ]  TTY

Fax: [ ]

E-mail: john.r.taitano@dphss.guam.gov

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

Last Name: [ ]

First Name: [ ]

Title: [ ]

Agency: [ ]

Address: [ ]

Address 2: [ ]

City: [ ]

State: Guam

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 section 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:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Guam**

Zip:

Phone:  Ext:   TTY

Fax:

E-mail:

**Attachments**

**Attachment #1: Transition Plan**

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

- Replacing an approved waiver with this waiver.
- Combining waivers.
- Splitting one waiver into two waivers.
- Eliminating a service.
- Adding or decreasing an individual cost limit pertaining to eligibility.
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- Reducing the unduplicated count of participants (Factor C).
- Adding new, or decreasing, a limitation on the number of participants served at any point in time.

- Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

**Additional Needed Information (Optional)**

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Provide additional needed information for the waiver (optional):

**Appendix A: Waiver Administration and Operation**

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**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:

The Division of Public Welfare

*(Do not complete item A-2)*

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

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

*(Complete item A-2-a).*

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

Specify the division/unit name:

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

**Appendix A: Waiver Administration and Operation**

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**2. Oversight of Performance.**

**a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella

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

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

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

**As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.**

### Appendix A: Waiver Administration and Operation

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**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

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**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

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**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:

**As indicated in sections 3 and 4 of this appendix, no non-Medicaid or non-State agency performs waiver administration. Thus this section does not need to be completed.**

### Appendix A: Waiver Administration and Operation

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**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:

**As indicated in sections 3 and 4 of this appendix, no non-Medicaid or non-State agency performs waiver administration. Thus this section does not need to be completed.**

### Appendix A: Waiver Administration and Operation

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**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.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

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

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

*Where possible, include numerator/denominator.*

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

**Performance Measure:**

**Provider agreements will be executed to ensure availability of DIESHA program providers and services across the geographic area of Guam**  
**Numerator: Number of provider agreements evidencing availability of DIESHA program providers and services across the geographic area of Guam**  
**Denominator: Total number of provider agreements**

**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 checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

Administrative compliance issues are resolved in a timely manner following a provider review. Numerator: Number of provider review deficiencies satisfactorily resolved (for example, timely submission of a corrective action plan) Denominator: Total number of administrative provider deficiencies found per waiver year

**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 checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

**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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

DPHSS will require corrective action for all instances of noncompliance. Individual problems will be addressed directly with the provider agency prior to the conclusion of the provider review. If issues are found to be systemic and/or pose a threat to the health, safety, and welfare of individuals served, follow-up reviews will be conducted to certify that all corrective action was implemented.

- 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 checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input 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 Administrative Authority that are currently non-operational.

- No
- Yes

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

**Appendix B: Participant Access and Eligibility**

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

- a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance*

with 42 CFR § 441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="checkbox"/> Aged or Disabled, or Both - General					
	<input checked="" type="checkbox"/>	Aged	64		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	18	64	
	<input checked="" type="checkbox"/>	Disabled (Other)	18	64	
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			<input type="checkbox"/>
	<input type="checkbox"/>	Serious Emotional Disturbance			<input type="checkbox"/>

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

The target population is adults with disabilities who are appropriate for a community-based LOC and would require an institutional LOC in the absence of adequate HCBS and supports. Exclusion criteria include histories of violence or criminal sexual conduct, ventilator dependency, election of hospice, being under age 18, and primary diagnoses of intellectual or developmental disability, severe and persistent mental illness (SPMI), dementia, and/or primary substance use disorder.

**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:

**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)

- 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:

Each individuals' level of need is assessed using the standardized functional assessment of need and includes review of relevant medical and social history. In the process of evaluating an individual's support needs, the DPHSS Kumunidât Diniseha: Community of Hope program staff conducting the assessment will also evaluate expected service needs, including an estimate of the cost to support the individual in a community-based setting. In the event that program staff suspect that an individual's needs may exceed the level of support available in the community (including both waiver services, state plan, informal, and natural supports), the DPHSS Multi-Disciplinary Team (MDT) will be consulted to review the individual case prior to the issuance of an eligibility determination. The MDT is comprised of leadership from each of DPHSS and GovGuam's operating agencies and has unique experience and expertise in the population needs, supports, and service array available on Guam. If the MDT finds that the individual's health, safety, and welfare cannot be effectively assured within the cost limit, the individual will be referred to a more comprehensive level of care to meet their individual needs.

- 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:

In the event that individual experiences a change in condition or circumstances following enrollment in the Kumunidât Diniseha: Community of Hope program that required the provision of services in an amount that exceeds the institutional cost limit, the waiver program case manager is responsible to convene the individual's person-centered care planning team to review and discuss the change in circumstances. If the individual's team is in agreement that the individual's needs can no longer be met due to a change in circumstance that is likely to be temporary or transient in nature, the individual make seek an exception for authorization of services in excess of the institutional cost limit on a time-limited basis, subject to DPHSS review and approval.

If the change in condition or circumstance is expected to continue indefinitely or is determined to be chronic, the individual's case will be referred to the MDT for review. The MDT is responsible for reviewing complex cases and making recommendations and referrals. The MDT's findings will be shared with the individual, their case manager and care planning team, and DPHSS. The individual, along with their case manager and care planning team, will evaluate the MDT's recommendation and determine whether a transition out of the waiver program and into an environment that can support a higher level of care is appropriate.

If the individual and their team is unable to reach a decision regarding the need to transition out of the waiver, the case manager will inform DPHSS waiver program staff and provide all relevant information and documentation. DPHSS program staff retain ultimate responsibility for waiver enrollment determinations, including discharges from the waiver for individuals who can no longer be safely supported with waiver services. Any adverse decision made by DPHSS program staff, including discharge or termination from the waiver, is subject to local fair hearing and administrative appeal rules and regulations. Any individual discharges from the Kumunidât Diniseha: Community of Hope program based on the need for supports beyond the institutional cost limit will be informed, in writing, of their right to appeal this decision through the fair hearing process.

**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	35
Year 2	45
Year 3	55

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	[ ]
Year 2	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 3	

**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 situations as determined by DPHSS and partner government agencies.

**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 situations as determined by DPHSS and partner government agencies.

**Purpose** (*describe*):

To respond to emergency situations and support individuals who meet the Kumunidât Diniseha: Community of Hope program eligibility requirements and are facing emergency situations that place them at imminent risk of hospitalization or other seriously adverse outcomes. This reserved capacity will allow Guam’s government agencies to effectively and efficiently allocate government resources to support individuals facing emergency situations and avoid unnecessary hospitalization or institutionalization (e.g., natural disasters, hazardous conditions, or unanticipated unavailability of caregiver support).

**Describe how the amount of reserved capacity was determined:**

Reserved capacity is estimated to be slightly higher in the initial years of the waiver to allow for evaluation of the need for emergency placements while facilitating as much access as possible through standard waiver enrollment processes.

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

Waiver Year	Capacity Reserved
Year 1	6
Year 2	6
Year 3	5

**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:

Policies that apply to selecting individuals for entrance to the waiver include:  
 Individuals can be referred to the Kumunidât Diniseha: Community of Hope program following findings of a brief, standardized pre-screen assessment available for use across all GovGuam client-serving organizations, including Guam Behavioral Health and Wellness Clinic (GBHWC), Division for Integrated Services for Individuals with Disabilities (DISID), the Division of Senior Citizens (DSC), and Guam Memorial Hospital (GMH).

The findings of the pre-screening assessment indicate:

- 1) The individual requires a nursing facility or hospital level of care but could return to or remain in the community with sufficient HCBS services and supports.
- 2) The individual wants to transition out of the institutional setting and return to their community of choice with waiver supports. For individuals who may be diverted from a hospital or nursing facility stay, the individual chooses to remain in their community of choice with waiver services and supports.
- 3) The individual’s current (or previous) home environment is unstable due to disability, lack of caregivers, environmental conditions, or other relevant factors.
- 4) The individual does not have a primary diagnosis(es) of an intellectual or developmental disability (I/DD), serious or serious and persistent mental illness (SMI/SPMI), and/or dementia.
- 5) There is a reasonable expectation, based on professional knowledge and direct observation, that the individual could return to or remain in their community of choice with home and community-based services and supports tailored to meet their unique needs.
- 6) The individual is over the age of 18
- 7) A licensed medical professional indicates that the individual may be supported in a community-based setting with adequate Kumunidât Diniseha: Community of Hope program services

If the waiver reaches enrollment capacity and requires a waitlist, DPHSS will operate on a first-come, first-served basis absent extenuating circumstances.

**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**

Note: Complete this section prior to starting B-5: Post-Eligibility Treatment of Income

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

- Section 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)*

---

- Parents and Other Caretaker Relatives (42 CFR § 435.110)
- Pregnant Women (42 CFR § 435.116)
- Infants and Children under Age 19 (42 CFR § 435.118)
- 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 section 1902(a)(10)(A)(ii)(XIII) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in section 1902(a)(10)(A)(ii)(XV) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in section 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 section 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 spend down in states which also provide Medicaid to recipients of SSI (42 CFR § 435.320, § 435.322 and § 435.324)**
- Medically needy without spend down in 209(b) States (42 CFR § 435.330)**
- Aged and disabled individuals who have income at:**

Select one:

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

Specify percentage amount:

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

Specify:

**Appendix B: Participant Access and Eligibility**

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

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

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 7)

*Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).*

- b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).**

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (3 of 7)

*Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).*

- c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).**

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (4 of 7)

*Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).*

- d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)**

The state uses the post-eligibility rules of section 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 section 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).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

## Appendix B: Participant Access and Eligibility

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

*Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).*

- e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through**

September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- f. Regular Post-Eligibility Treatment of Income: 209(b) State – January 1, 2014 through September 30, 2027 (or other date as required by law).**

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

## Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – January 1, 2014 through September 30, 2027 (or other date as required by law).**

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

## 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:

DPHSS staff conducting standardized functional assessments of need and eligibility determinations must have a bachelor’s degree in a social science, human services, public health, nursing, or other closely related field. These staff must also receive training specific to the assessment policies and practices of the Kumunidât Diniseha: Community of Hope program and demonstrate competency in person-centered thinking, practices and planning, as determined by DPHSS.

**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.

An individual's standardized functional assessment of need to determine eligibility and level of care will be conducted using the Functional Assessment Standardized Items (FASI) tool. DPHSS adapted the FASI to include additional standardized assessments of cognitive function, substance use disorder (SUD), and mental health needs. This standardized functional assessment is comprehensive and will be conducted in person by DPHSS staff.

The assessment includes an evaluation of the individual's ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs), medical needs, safety and supervision, behavioral health needs, and community and family supports. The assessor uses this assessment to evaluate and understand the individual's needs and determine if they can be safely supported in a community-based setting with waiver program services.

The standardized functional assessment of need determines whether the applicant is able to:

- Meet their personal care needs
- Perform household management tasks
- Communicate basic wants and needs, and ensure their own safety
- Access community resources

The findings of the standardized functional assessment of need must find that an individual needs support in at least TWO of the following areas:

- Physical assistance or ongoing supervision to accomplish ADLs or someone to complete ADLs for the individual
- Physical assistance or ongoing supervision to accomplish IADLs to decrease vulnerability for self-neglect or maltreatment by another, or someone to complete IADLs for the individual
- Assistance with ADLs or IADLs resulting from a sensory impairment
- Extended State plan home health care or other delegated health services necessary to prevent or delay nursing facility admission secondary to a complex or unstable medical need
- Home modification, equipment or environmental remediation that will maximize independence and contribute to meeting health and safety needs
- Services or supports to access community resources or maintain social networks and relationships
- Caregiver supports to supplement and extend supports provided by informal caregivers
- Supervision, direction, cueing, or hands-on assistance to perform ADLs or IADLs due to cognitive or behavioral limitations
- Intensive, transitional services and supports to reconnect with family, loved ones, or other community resources needed to sustain independence in their community setting of choice

In addition to the eligibility criteria listed above, additional exclusionary criteria will also be evaluated during the functional assessment of need to help ensure the effectiveness and sustainability of the Kumunidât Diniseha: Community of Hope program. Specifically, the Kumunidât Diniseha: Community of Hope program is not intended to support youth under age 18, individuals with a primary diagnosis an intellectual or developmental disability (I/DD), severe mental illness (SMI) or severe and persistent mental illness (SPMI), or dementia. In addition, the functional assessment of need should indicate that the individual will be able to sustain community tenure with adequate services and supports.

DPHSS does not currently employ a standardized tool to determine institutional level of care for nursing facility admissions. However, by definition, the target population for this waiver is either already institutionalized or at risk of institutional placement. To ensure that level of care determinations are reliable, valid, and comparable to existing institutional evaluations, DPHSS has elected to adopt the FASI, a peer-reviewed, standardized assessment instrument.

As DPHSS continues to develop and expand HCBS in Guam—including the use of standardized functional assessments for determining program eligibility and level of care—it is expected that the consistent use of these assessment tools will become standard practice across service settings. This approach will support uniformity, accuracy, and equity in assessing individuals' needs throughout both the institutional and HCBS systems of care.

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 functional assessment of need and eligibility determination will be completed using the adapted FASI. This standardized functional assessment is comprehensive and will be conducted in person by authorized DPHSS staff. The assessment includes ADLs, IADLs, medical needs, safety and supervision, behavioral health needs, and community and family supports. The assessor uses this assessment to evaluate and understand the individual's needs and determine if they can be safely supported in a community-based setting with waiver program services. The HCBS assessment instrument differs from the institutional care assessment because the HCBS assessment is focused on functional needs with the goal of developing a person-centered plan of care, distinct from clinical and institutional decision-making. The assessment tool is a validated instrument for the identification of functional needs and is performed by DPHSS waiver operations staff dedicated to the HCBS population and to supporting transitions to least-restrictive settings. If an individual has a recently completed PASSR Level I or Level II screen, the DPHSS assessor may review and consult the findings of the PASSR to inform the functional eligibility determination, if appropriate. The eligibility determination may be based on a variety of conditions or support needs as identified in the FASI, including complex medical needs, unstable health, long-term need for assistance with ADLs or IADLs, underlying mental health or SUD needs, or other cognitive or behavioral impairments that indicate the need for ongoing supervision and/or assistance to prevent unnecessary institutionalization.

- 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:

DPHSS identified and developed a comprehensive standardized functional assessment of need to be used for both initial and eligibility re-determinations as described in previous sections.

The assessment will be conducted in person by authorized DPHSS staff.

The level of care evaluation and reevaluation will be completed using the adapted FASI. This standardized functional assessment is comprehensive and will be conducted in person by authorized DPHSS staff.

The assessment includes ADLs, IADLs, medical needs, safety and supervision, behavioral health needs, and community and family supports. The assessor uses this assessment to evaluate and understand the individual's needs and determine if they can be safely supported in a community-based setting with waiver program services.

The HCBS assessment instrument differs from the institutional care assessment because the HCBS assessment is focused on functional needs with the goal of developing a person-centered plan of care, distinct from clinical and institutional decision-making. The assessment tool is a validated instrument for the identification of functional needs and is performed by DPHSS waiver operations staff dedicated to the HCBS population and to supporting transitions to least-restrictive settings. If an individual has a recently completed PASSR Level I or Level II screen, the DPHSS assessor may review and consult the findings of the PASSR to inform the functional eligibility determination, if appropriate. The eligibility determination may be based on a variety of conditions or support needs as identified in the FASI, including complex medical needs, unstable health, long-term need for assistance with ADLs or IADLs, underlying mental health or SUD needs, or other cognitive or behavioral impairments that indicate the need for ongoing supervision and/or assistance to prevent unnecessary institutionalization.

- 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:*

The standardized functional assessment of need will be re-administered every three months during the first year of the individual's enrollment and then every six months thereafter. More frequent assessment during the initial phases of program enrollment will assist DPHSS in refining waiver program operations, including the needs of the target population and adequacy of the service array and provider network, to help ensure that the waiver design is meeting the needs of the target population.

- 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*):

For the initial enrollment year, the individual’s LOC functional assessment and eligibility re-determinations will occur every three months and assessments must be conducted 10 – 15 business days before the expiration of the existing assessment and eligibility determination. For subsequent enrollment years, assessments and eligibility re-determinations will occur every six months and be conducted 10-15 business days prior the expiration of the existing evaluation. Timeliness will be managed through organizational policy, procedure, and supervision by DPHSS.

DPHSS Kumunidât Diniseha: Community of Hope operations staff will maintain internal records of participant intake and eligibility assessments, and eligibility determination and re-determination timelines.

**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:

## Appendix B: Evaluation/Reevaluation of Level of Care

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### 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**

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**Percentage of waiver applicants and participants who had a functional assessment and eligibility re-determination performed within required timeframes. Numerator: Total number of functional assessments and eligibility re-determinations completed within required time frames Denominator: Total number of functional assessments and eligibility determinations.**

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <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 checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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 the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

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

**Performance Measure:**

**Individuals are re-evaluated every three months during their first year of waiver enrollment and biannually thereafter**  
**Numerator: Total number of assessments performed within required timelines**  
**Denominator: Total number of assessments completed**

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> <b>Other</b>	

	Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>	
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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 type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>

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

**Performance Measures**

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

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

**Performance Measure:**

**All individuals enrolled in the waiver have a standardized assessment that reflects eligibility criteria**  
**Numerator: Number of assessments for enrolled waiver participants that meet defined eligibility criteria**  
**Denominator: Total number of assessments.**

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 30px; margin-top: 5px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 30px; margin-top: 5px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 30px; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 30px; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input 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 type="checkbox"/> Other	<input type="checkbox"/> Annually

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
Specify: <input type="text"/>	
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

Person-centered plans are reviewed and approved by DPHSS in accordance with established timelines  
**Numerator:** Number of service plans reviewed and approved in accordance with established timelines  
**Denominator:** Total number of plans reviewed

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

	<input type="checkbox"/> <b>Other</b> Specify:  	

**Data Aggregation and Analysis:**

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

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

- DPHSS has implemented a standardized functional assessment to assess eligibility and LOC by a single intake and eligibility entity (DPHSS), a waiver enrollment tracking system, and quality management processes to administer and provide oversight of intake, eligibility, and enrollment in waiver services.
- The standardized functional assessment protocol and waiver eligibility and redetermination of eligibility tracking system will enable the timely delivery of services and identification of sustainable assessment and management practices.
- The quality oversight process will derive from existing DPHSS processes as well as the assessment and data management systems and will be in place by Month 6 of waiver implementation to ensure that development, implementation and oversight of the functional assessment of need and eligibility determinations processes.
- Guam is undertaking Medicaid enterprise systems modernization with the goal of improving efficiency of existing systems. This effort will enable electronic data systems for storing, tracking, and reporting data regarding functional assessments and eligibility determinations.

Each element of the application, eligibility determination, enrollment, and service authorization will be monitored by DPHSS waiver program staff on a monthly basis to proactively assess system performance. Any areas of concern will be documented and shared with DPHSS leadership, as well as internal and external stakeholder groups to identify opportunities to improve program operations. This monthly system performance review will remain in place for the first year of waiver

program operations and may be modified by DPHSS with input from waiver program providers, stakeholders, and the broader community.

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

- When an individual problem is identified (e.g., missing functional assessment and/or eligibility re-determination) by DPHSS waiver operations staff, a case manager, supervisor, or by quality assurance personnel, the individual who identified the issue logs a corrective action with their supervisor and with the DPHSS waiver operations staff within 10 business days.
- Corrective actions may include updating documentation, completing overdue assessments, revising service plans, providing technical assistance to DPHSS waiver operations staff or providers, or updating processes.
- DPHSS waiver operations staff review and approve corrections to ensure compliance with waiver requirements.
- All actions are logged in the DPHSS system, including date of discovery, corrective actions taken, and resolution date. Information is retained for CMS or other regulatory review.
- DPHSS will review problems and corrective actions on a monthly basis during the first year of waiver operations and then on a quarterly basis thereafter, to identify, document, and evaluate systemic issues and implement preventive policies and practices.
- DPHSS partners and stakeholders will receive briefings on systemic issues for collaborative mitigation, particularly in instances where the work of external entities (e.g., referring agencies) is implicated in the problem, corrective action, or preventive policy and practice.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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 Level of Care that are currently non-operational.

- No**
- Yes**

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

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

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

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

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

DPHSS has developed a standardized form to document each Kumunidåt Diniseha: Community of Hope program participant's choice to pursue community-based services and supports rather than institutional services. This form will be presented at the time of the in-person functional assessment of need for the program participant's review and signature. The assessor is responsible for explaining that the individual is eligible for both institutional and HCBS and for documenting the individual's preference for waiver services and supports.

While Guam has an exemption from CMS regarding free choice of providers, DPHSS aims to provide as much meaningful choice as feasible to program participants, where possible. DPHSS will endeavor to engage and enroll internal and external provider partners for participation in both case management and direct service provision on an ongoing basis. Once sufficient provider enrollment and participation is achieved, DPHSS will develop and implement a process to inform program participants of their choice of waiver service providers, including implementation of a standardized form to acknowledge and document an individual's choice of providers.

**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.

- Written or electronic copies of Freedom of Choice forms will be maintained for a minimum of three years in Guam's case management and waiver enrollment system.
- Freedom of Choice forms will also be shared with the individual's case management agency. The Freedom of Choice form must be maintained by the case management agency for a minimum of three years.

## 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):

- Language Assistance Services: DPHSS provides free oral interpretation and written translation of important documents in prevalent languages.
- Qualified Interpreters: DPHSS will establish a roster of trained interpreters available for in-person and telephonic services.
- Notice of Rights: DPHSS informs participants of their right to language assistance through multilingual notices in application materials and public postings.

## 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		
Extended State Plan Service	Nursing		
Extended State Plan Service	Occupational Therapy		
Extended State Plan Service	Physical Therapy		
Extended State Plan Service	Speech and Language Therapy		
Other Service	Adaptive Aids		
Other Service	Adult Day Services		
Other Service	Arts Therapy		
Other Service	Case Management		
Other Service	Home Delivered Meals		
Other Service	Home Modifications		
Other Service	Home-Based Support Services		
Other Service	Residential Support Services		
Other Service	Respite		
Other Service	Therapeutic Support Services		
Other Service	Transition Assistance		
Other Service	Vehicle Modifications		
Other Service			

### Appendix C: Participant Services

#### C-1/C-3: Service Specification

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

**Service Type:**

Extended State Plan Service

**Service Title:**

Nursing

**HCBS Taxonomy:**

**Category 1:**

05 Nursing

**Sub-Category 1:**

05020 skilled nursing

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Nursing services are those services needed by the participant, described in the person-centered plan, and designed to enable the participant to integrate more fully into their community of choice. Nursing services help ensure the health, safety, and

welfare of the individual. Nursing services must be performed by an RN or LPN and delivered within the RN or LPN’s scope of practice. Nursing services may be continuous, intermittent, or short term based on the individual’s assessed needs. The nurse is responsible for documenting and reporting any changes in the participant’s health status. Changes in the individual’s health status must be shared with the individual’s case manager and, if needed, documented in the individual’s person-centered plan. The nursing provider must maintain all documentation in accordance with local rules and regulations governing the nursing practice. This documentation must always be available to the individual and their case manager for monitoring.

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

Nursing services will be reimbursed in 15-minute increments. Nursing services may not duplicate services that might be available to the participant under the State plan. Nursing services may only be funded through the waiver when the services are not covered by state plan, Medicare, or other private insurance. However, nursing services may be funded through the waiver once state plan, Medicare or other private insurance service limits have been reached or when nursing services are not covered or have been denied by Medicare or other private insurance.

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

- Participant-directed as specified in Appendix E
- Provider managed
- Remote/via Telehealth

**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	Enrolled Medicaid provider agency licensed to operate pursuant to code and regulations

**Appendix C: Participant Services**

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

**Service Type:** Extended State Plan Service

**Service Name:** Nursing

**Provider Category:**

Agency

**Provider Type:**

Enrolled Medicaid provider agency licensed to operate pursuant to code and regulations

**Provider Qualifications**

**License** (specify):

Nurses licensed under 25 GAR Professional & Vocational Regulations Ch. 6 Guam Board of Nurse Examiners

**Certificate** (specify):

N/A

**Other Standard** (specify):

N/A

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DPHSS

**Frequency of Verification:**

Initially upon enrollment and annually thereafter. Verification may occur more often as needed and determined by DPHSS

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:

Extended State Plan Service

Service Title:

Occupational Therapy

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11080 occupational therapy

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Occupational therapy services are services delivered to the participant to assist in their acquisition, retention, or improvement in skills that support the individual to integrate more meaningfully into their community of choice. Occupational therapy services also help to ensure the individual’s health, safety, and welfare. Occupational therapy services must be designed to meet an assessed need and described in the individual’s person-centered plan of care. The occupational therapy service also includes training unlicensed personal care and adult family care staff, as well as developing a program for those staff to implement the occupational therapist’s recommendations. The occupational therapist must monitor and document any changes in the individual’s needs or health status and is responsible for reporting any changes to the individual’s case manager and care planning team. Occupational therapy may only be provided by a therapist licensed under 10 GCA Health and Safety Ch. 12 Medical Practices Part 2. All occupational therapy providers and services must meet the requirements of 42 CFR440.110. The occupational therapy provider must maintain documentation in accordance with DPHSS requirements. All documents must be always available to the individual and their case manager. The case manager will monitor service documentation on an ongoing basis to evaluate whether the individual’s needs, goals, and preferred outcomes are being met.

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

Occupational therapy services may not be provided under the waiver until the limits of State plan, Medicare, or other private insurance services are exhausted or denied. The amount, frequency, and duration of occupational therapy services are limited to the assessed needs as identified and documented in the individual’s person-centered plan of care.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed
- Remote/via Telehealth

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	Medicaid-enrolled home health agency, licensed occupational therapist enrolled as a Medicaid provider

### Appendix C: Participant Services

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

Service Type: Extended State Plan Service  
 Service Name: Occupational Therapy

Provider Category:

Individual

Provider Type:

Medicaid-enrolled home health agency, licensed occupational therapist enrolled as a Medicaid provider

Provider Qualifications

License (specify):

Occupational therapist licensed in accordance with 10 GCA Health and Safety Ch. 12 Medical Practices Part 2. All occupational therapy providers and services meet the requirements of 42 CFR440.110.

Certificate (specify):

N/A

Other Standard (specify):

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DPHSS

Frequency of Verification:

Initially upon enrollment and annually thereafter. Verification may occur more often as needed and determined by DPHSS

### 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:

Extended State Plan Service

**Service Title:**

Physical Therapy

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services

**Sub-Category 1:**

11090 physical therapy

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Physical therapy services are services delivered to the participant to assist in their acquisition, retention, or improvement in skills that support the individual to integrate more meaningfully into their community of choice. Physical therapy services also help ensure the individual’s health, safety, and welfare. Physical therapy services must be designed to meet an assessed need and described in the individual’s person-centered plan of care. The physical therapy service also includes training unlicensed personal care and adult family care staff, as well as developing a program for those staff to implement the physical therapist’s recommendations.

The physical therapist must monitor and document any changes in the individual’s needs or health status and is responsible for reporting any changes to the individual’s case manager and care planning team. Physical therapy may only be provided by a therapist licensed under 10 GCA Health and Safety Ch. 12 Medical Practices Part 2. All physical therapy providers and services meet the requirements of 42 CFR 440.110.

The physical therapy provider must maintain documentation in accordance with DPHSS requirements. All documents must be always made available to the individual and their case manager. The case manager will monitor service documentation on an ongoing basis to evaluate whether the individual’s needs, goals, and preferred outcomes are being met.

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

Physical therapy services may not be provided under the waiver until the limits of State plan, Medicare, or other private insurance services are exhausted or denied. The amount, frequency, and duration of physical therapy services are limited to the assessed needs as identified and documented in the individual’s person-centered plan of care.

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

- Participant-directed as specified in Appendix E
- Provider managed
- Remote/via Telehealth

**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	Medicaid-enrolled home health agency, licensed physical therapist enrolled as a Medicaid provider

### Appendix C: Participant Services

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

**Service Type:** Extended State Plan Service

**Service Name:** Physical Therapy

**Provider Category:**

Individual

**Provider Type:**

Medicaid-enrolled home health agency, licensed physical therapist enrolled as a Medicaid provider

**Provider Qualifications**

**License (specify):**

Physical therapist licensed in accordance with 10 GCA Health and Safety Ch. 12 Medical Practices Part 2. All physical therapy providers and services meet the requirements of 42 CFR 440.110.

**Certificate (specify):**

N/A

**Other Standard (specify):**

N/A

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DPHSS

**Frequency of Verification:**

Initially upon enrollment and annually thereafter. Verification may occur more often as needed and determined by DPHSS

### 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:**

Extended State Plan Service

**Service Title:**

Speech and Language Therapy

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services

**Sub-Category 1:**

11100 speech, hearing, and language therapy

**Category 2:**

**Sub-Category 2:**

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

**Service Definition (Scope):**

Speech therapy involves services delivered to the participant to assist in their acquisition, retention, or improvement in skills that support the individual to integrate more meaningfully into their community of choice. Speech therapy services also help ensure the individual’s health, safety, and welfare. Speech therapy services must be designed to meet an assessed need and described in the individual’s person-centered plan of care. The speech therapy service also includes training unlicensed personal care and adult family care staff, as well as developing a program for those staff to implement the speech therapist’s recommendations.

The speech therapist must monitor and document any changes in the individual’s needs or health status and is responsible for reporting any changes to the individual’s case manager and care planning team. Speech therapy may only be provided by a therapist licensed under 10 GCA Health and Safety Ch. 12 Medical Practices Part 2. The speech therapy provider must maintain documentation in accordance with DPHSS requirements. All documents must be always available to the individual and their case manager. The case manager will monitor service documentation on an ongoing basis to help ensure services are delivered in accordance with the person-centered plan.

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

The amount, frequency, and duration of speech therapy services are limited to the assessed needs as identified and documented in the individual’s person-centered plan of care.

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

- Participant-directed as specified in Appendix E
- Provider managed
- Remote/via Telehealth

**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	Medicaid-enrolled home health agency, licensed speech and language therapist enrolled as a Medicaid provider

**Appendix C: Participant Services**

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

Service Type: Extended State Plan Service

Service Name: Speech and Language Therapy

**Provider Category:**

Individual

**Provider Type:**

**Provider Qualifications**

License (specify):

Certificate (specify):

Other Standard (specify):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Speech and Language Therapy**

**Provider Category:**

Agency

**Provider Type:**

Medicaid-enrolled home health agency, licensed speech and language therapist enrolled as a Medicaid provider

**Provider Qualifications**

**License (specify):**

Speech and language therapist licensed in accordance with 10 GCA Health and Safety Ch. 12 Medical Practices Part 2

**Certificate (specify):**

N/A

**Other Standard (specify):**

N/A

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DPHSS

**Frequency of Verification:**

Initially upon enrollment and annually thereafter. Verification may occur more often as needed and determined by DPHSS

**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:**

Adaptive Aids

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14031 equipment and technology

**Category 2:**

14 Equipment, Technology, and Modifications

**Sub-Category 2:**

14032 supplies

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Adaptive aids are services or items that provide direct medical benefit or remedial benefit to the waiver participant and are directly related to the waiver participant’s disability. Adaptive aids are necessary to help ensure the health, safety and welfare of the waiver participant and support the waiver participant to live in their home and community with greater independence. Adaptive aids are intended to enable waiver participants to increase, maintain, or improve their ability to perform ADLs or IADLs.

Adaptive Aids include:

- Incontinence supplies, including adult pull-ons, briefs, bladder control pads, and underpads, protective and absorbent underwear, barrier creams and wipes, and no-rinse cleansers
- Enteral nutrition supplies, including nutritional shakes and supplements, and other supplies necessary to help ensure safe administration of enteral nutrition
- Devices, controls, or appliances, specified in the service plan, that enable participants to increase, maintain or improve their ability to perform ADLs
- Equipment repair and maintenance, unless covered by the manufacturer warranty
- Items that exceed the limits set for Medicaid State plan covered services
- Rental Equipment. In certain circumstances, needs for equipment or supplies may be time limited. The case manager must initially verify that the rental costs cannot be covered by the State Plan. If the State Plan does not cover the rental for the particular piece of equipment needed, then the cost of the rental can be funded through Adaptive Aids
- Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants
- Selecting, designing, fitting, connecting, customizing, adapting, applying, maintaining, installing, programming, repairing or replacing assistive technology devices. Repairs are covered when it is more cost effective than purchasing a new device and the device or repairs are not covered under a warranty
- Electronic systems that enable a participant with functional limitations and identified needs to control various appliances, lights, telephone, doors and security systems in their room, home or other surroundings
- Electronic devices that assist a participant with communication or prompting needs such as tablets, computers and electronic communication aids
- Training or technical assistance for the participant, or where appropriate, the participant’s family members, paid caregivers, and informal supports on the use of assistive technology
- An independent evaluation of the assistive technology needs of a participant. This includes a functional evaluation of the assistive technology needs and appropriate services for the participant in his/her customary environment
- Extended warranties
- Ancillary supplies, software, mobile apps, hubs and equipment necessary for the proper functioning of assistive technology devices, such as replacement batteries and materials necessary to adapt low-tech devices. This includes applications for electronic devices that assist participants with a communication or prompting need identified through the independent evaluation or physician’s prescription described below
- Generators to power life-sustaining equipment are covered for waiver participants residing in their own home or a family

home when the following has been documented: the generator purchased is the most cost-effective to help ensure the health and safety of the participant; AND the participant’s health and safety is dependent upon electricity as documented by a physician.

- For any item not listed, Adaptive Aids funds may be used for an item or service that would decrease the need for other Medicaid services, and/or promote full inclusion in the community, and/or increase the individual’s safety in there home. Any item not specifically listed may only be purchased with Adaptive Aids funds with a written referral from a licensed medical professional.

All items purchased through adaptive aids shall meet the applicable standards of manufacture, design, and/or installation.

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

Adaptive aids services are limited to the needs and objectives of the service as identified and described in the participant’s person-centered plan of care. Adaptive aids may be funded through the waiver only when the service is not covered by Medicaid, Medicare, private insurance, or other responsible payors and all alternative funding sources have been exhausted. Service limits apply, to be determined by DPHSS. The provision of adaptive aids services must be based on an independent evaluation of need by an appropriately licensed professional and provided in a cost-effective manner.

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

- Participant-directed as specified in Appendix E
- Provider managed
- Remote/via Telehealth

**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	Provider Agency, Durable Medical Equipment Provider, Other Agency as authorized by DPHSS

**Appendix C: Participant Services**

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

**Service Type:** Other Service  
**Service Name:** Adaptive Aids

**Provider Category:**

Individual

**Provider Type:**

Provider Agency, Durable Medical Equipment Provider, Other Agency as authorized by DPHSS

**Provider Qualifications**

**License** (specify):

N/A

**Certificate** (specify):

N/A

**Other Standard** (specify):

Vendor licensed in accordance with local rules and required by trade; durable medical equipment, Medicaid-enrolled provider agency

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DPHSS

**Frequency of Verification:**

Initially upon enrollment and annually thereafter. Verification may occur more often as needed and determined by DPHSS Respite

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Adult Day Services

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04060 adult day services (social model)

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Adult day services provide structured, community-based daytime services in an integrated setting for individuals who require supervision, support, and assistance to remain safe and engaged in the community. Services are designed to support health and safety, promote social engagement, and provide meaningful activities consistent with the participant’s preferences and person-centered plan. Adult day services environments are embedded across Guam’s villages, with the support of the mayor’s offices, and are designed to foster and enhance a sense of community. Adult day services include supervision and supportive services to help ensure participant health and safety during program hours and to support community engagement. Services may include assistance with ADLs and IADLs, including hands-on personal care, cueing, and standby assistance, as needed and authorized in the person-centered plan. Adult day services take place in small group settings and are provided in settings that are separate from the participant’s residence.

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

Adult day services are billed in 15-minute increments. No more than eight hours (32 units) may be billed per day. Adult day services may not be billed on weekends without authorization by DPHSS.

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

Participant-directed as specified in Appendix E

- Provider managed**
- Remote/via Telehealth**

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Adult Day Services Provider

### Appendix C: Participant Services

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

**Service Type:** Other Service  
**Service Name:** Adult Day Services

**Provider Category:**

Agency

**Provider Type:**

Adult Day Services Provider

**Provider Qualifications**

**License** *(specify):*

N/A

**Certificate** *(specify):*

N/A

**Other Standard** *(specify):*

Enrolled Medicaid provider, senior center operated by the Mayor’s Council of Guam

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DPHSS

**Frequency of Verification:**

Initially upon enrollment and annually thereafter. Verification may occur more often as needed and determined by DPHSS Respite

### 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:**

Arts Therapy

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services

**Sub-Category 1:**

11130 other therapies

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Arts therapies are provided to waiver participants with a co-occurring mental or behavioral health need. Arts therapies support individuals to draw on their inner, creative resources to explore personal issues with a trained arts therapist in a safe space in order to achieve desired psychological, mental health, or other individual therapeutic goal. Arts therapies on Guam include Art, Dance Movement, Drama, and Music. Arts therapies practitioners are trained to post-graduate level and must be registered by Guam to practice.

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

Arts therapies will be reimbursed at 15-minute increments. The need for arts therapy must be on the person-centered plan and delivered in accordance with the amount, frequency, and duration described in the plan. Arts therapies will not exceed 40 units (or 10 hours) per month

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

- Participant-directed as specified in Appendix E
- Provider managed
- Remote/via Telehealth

**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	Enrolled Medicaid Provider Agency

**Appendix C: Participant Services**

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

Service Type: Other Service  
 Service Name: Arts Therapy

**Provider Category:**

Agency

**Provider Type:**

Enrolled Medicaid Provider Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Enrolled Medicaid provider employing staff with training and qualifications, including licensure when applicable, sufficient to deliver the arts therapies service; independent registered arts therapies practitioner enrolled as a Medicaid provider.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DPHSS

**Frequency of Verification:**

Initially upon enrollment and annually thereafter. Verification may occur more often as needed and determined by DPHSS Respite

**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:**

Case Management

**HCBS Taxonomy:**

**Category 1:**

01 Case Management

**Sub-Category 1:**

01010 case management

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Case management helps participants access waiver and state plan services by coordinating with families, natural supports, and providers to identify formal and informal supports that help ensure health, safety, and community living. The case manager develops a person-centered plan detailing services, providers, and the frequency and duration of supports, with the participant actively involved in all decisions. Participants have the right to choose when, how, and where services are delivered. The plan must be completed at the initial meeting, reviewed every three months during the first year, and reviewed at least every six months thereafter. Case managers monitor implementation through monthly face-to-face meetings and help ensure services align with participant preferences. Participants may request plan updates at any time.

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

Case management is provided on an ongoing basis throughout the individual’s participation in the waiver program. Case managers will, at a minimum, conduct monthly face-to-face meetings with the individual as well as quarterly reviews and updates to the person-centered plan. Case Management services are authorized and billed at a monthly rate.

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

- Participant-directed as specified in Appendix E
- Provider managed
- Remote/via Telehealth

**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	Enrolled Medicaid Case Management Provider Agency

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Case Management**

**Provider Category:**

Agency

**Provider Type:**

Enrolled Medicaid Case Management Provider Agency

**Provider Qualifications**

**License (specify):**

N/A

**Certificate (specify):**

N/A

**Other Standard (specify):**

Case management agencies must be enrolled as a Medicaid provider and obtain licenses necessary to operate a business on Guam in accordance with local rules and regulations. A case management agency must employ staff with appropriate experience and knowledge regarding person-centered thinking, planning, and systems. Case management agencies must employ case managers who have a bachelor’s degree in social work or other human service areas of study. In lieu of a bachelor’s degree, case managers may have substituted experience working directly with individuals with disabilities. Case management agencies must have mandatory annual training programs for all case management staff. Areas of required training include person-centered thinking and planning, HCBS Settings Rule requirements, waiver program participants’

rights and responsibilities, service documentation, identifying, reporting, and responding to allegations of abuse, neglect, or exploitation, and reporting and responding to complaints and grievances. Case management agencies must have documented contingency plans to ensure continuity of services in the event of a disaster or emergency.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DPHSS

**Frequency of Verification:**

Initially upon enrollment and annually thereafter. Verification may occur more often as needed and determined by DPHSS

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Home Delivered Meals

**HCBS Taxonomy:**

**Category 1:**

06 Home Delivered Meals

**Sub-Category 1:**

06010 home delivered meals

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Home delivered meals include the delivery of nutritionally balanced meals to the participant’s residence. Concurrent monitoring of the participant’s well-being, socialization, and reporting of emergencies, crises, or other potentially harmful situations is a collateral benefit of this service. Home delivered meal service providers must communicate any concerns regarding the individual’s well-being to their case manager and/or service planning team.

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

No more than three meals per day may be authorized or billed.

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

- Participant-directed as specified in Appendix E
- Provider managed
- Remote/via Telehealth

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	Home Delivered Meals provider

### Appendix C: Participant Services

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

Service Type: Other Service  
 Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Home Delivered Meals provider

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

Division of Senior Centers authorized vendors, Mayor’s Council of Guam

Verification of Provider Qualifications

Entity Responsible for Verification:

DPHSS

Frequency of Verification:

Initially upon enrollment and annually thereafter. Verification may occur more often as needed and determined by DPHSS

### Appendix C: Participant Services

#### C-1/C-3: Service Specification

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

Service Type:

Other Service

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

**Service Title:**

Home Modifications

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14020 home and/or vehicle accessibility adaptations

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Home modifications are physical adaptations to the primary private residence of the participant, as specified in the participant's person-centered plan of care and determined necessary in accordance with the participant's unique individual needs to help ensure their health, welfare, and safety and enable the participant to function with greater independence in the home. This includes modifications that facilitate primary egress into and out of the home, facilitate personal hygiene, and support the ability to access common shared areas within the home. Home modifications consist of installation, repair, maintenance, permits, necessary inspections, and extended warranties.

Examples of modifications to a home include:

- o Ramps from street, sidewalk, or house
- o Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the health, welfare, and safety of the participant
- o Vertical lifts
- o Track lift systems that involve the installation of a "track" in the ceiling for moving a participant with a disability from one location to another
- o Handrails and grab-bars in and around the home
- o Accessible alerting systems for smoke/fire/carbon monoxide for participants with sensory impairments; case managers must first seek these types of alert systems from local municipalities and/or fire departments
- o Outside railing to safely access the home
- o Widened doorways, landings, and hallways
- o Swing-clear and expandable offset door hinges
- o Flush entries and leveled thresholds
- o Slip-resistant flooring
- o Kitchen counter, sink, and other cabinet modifications (including brackets for appliances); these types of adaptations will be considered only when the participant will be preparing their own meals, or the adaptation reduces the participant's dependence upon another person
- o Bathroom adaptations for bathing, showering, toileting, and personal care needs
- o Stair gliders and stair lifts; a stair lift is a chair or platform that travels on a rail, installed to follow the slope and direction of a staircase, which allows a user to ride up and down stairs safely
- o Raised electrical switches and sockets
- o Other adaptations, subject to DPHSS approval, to address specific assessed needs as identified in the person-centered plan of care

All modifications to the home shall be provided in accordance with applicable local building codes. In addition, the home modifications contractor is responsible for helping ensure that the residential dwelling is structurally sound and can accommodate the proposed modification before proceeding with the modification. In addition, home modifications must be an item or adaptation that the family would not be expected to provide to a family member without a disability or

specialized need.

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

Home modifications may be funded through the waiver only when the service is not covered by Medicare, private insurance, or other responsible payors and all alternative funding sources have been exhausted. Service limits apply, to be determined by DPHSS. Modifications must be based on an independent evaluation of need by an appropriately licensed professional and provided in a cost-effective manner in a structurally sound home. General home maintenance and non-medical upgrades are excluded, and modifications completed during institutionalization are not reimbursable until the individual transitions to the home under the waiver. For rental properties, there must be a reasonable expectation of continued residency, along with written landlord approval confirming that rent will not increase and waiver funds will not be used to restore the property or remove the modification.

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

- Participant-directed as specified in Appendix E
- Provider managed
- Remote/via Telehealth

**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	Contractor licensed to do business on Guam, durable medical equipment provider

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Home Modifications**

**Provider Category:**

Individual

**Provider Type:**

Contractor licensed to do business on Guam, durable medical equipment provider

**Provider Qualifications**

**License (specify):**

N/A

**Certificate (specify):**

N/A

**Other Standard (specify):**

Contractor licensed in accordance with local rules and required by trade; durable medical equipment provider enrolled as a Medicaid provider

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DPHSS

**Frequency of Verification:**

Initially upon enrollment and annually thereafter. Verification may occur more often as needed and determined by DPHSS

### Appendix C: Participant Services

#### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Home-Based Support Services

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08030 personal care

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Home-based supports include a combination of hands-on personal care, homemaker services, and other supports, such as direct and indirect supervision, provided in the participant’s home or family member’s home. Home-based support services may be provided by the participant’s family member(s) who also live in the individual’s home. Home-Based Support Services also include assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) that participants would typically perform independently if not for a disability, including cueing, and standby assistance, as appropriate. Home-Based Supports Services also include direct, in-person supervision, monitoring, and redirection to help prevent harm and respond to health and safety needs (for example, when an individual is at risk of wandering or engaging in unsafe behaviors).

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

Home-based support services will be reimbursed in 15-minute increments. The provision of home-based supports services must be authorized by DPHSS and delivered as described in the individual’s person-centered care plan. Providers may bill a maximum of 16 hours/day, unless otherwise authorized by DPHSS.

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

- Participant-directed as specified in Appendix E
- Provider managed
- Remote/via Telehealth

**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	Enrolled Medicaid provider agency licensed to operate pursuant to code and regulations

**Appendix C: Participant Services**

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

**Service Type:** Other Service  
**Service Name:** Home-Based Support Services

**Provider Category:**

Individual

**Provider Type:**

Enrolled Medicaid provider agency licensed to operate pursuant to code and regulations

**Provider Qualifications**

**License (specify):**

N/A

**Certificate (specify):**

N/A

**Other Standard (specify):**

Home-based supports providers must be trained to deliver services pursuant to DPHSS training standards. In addition to standard training requirements, home-based supports providers must be trained on the individual’s unique support needs and preferences. Provider agencies delivering home-based supports services must conduct required background checks of all staff working directly with waiver participants upon hire and annually thereafter.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DPHSS

**Frequency of Verification:**

Initially upon enrollment and annually thereafter. Verification may occur more often as needed and determined by DPHSS

**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:**

Residential Support Services

**HCBS Taxonomy:**

**Category 1:**

02 Round-the-Clock Services

**Sub-Category 1:**

02033 in-home round-the-clock services, other

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Residential Support Services are provided in an assisted living residence to help ensure individuals can live safely in a community-based residential setting. Services include assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) that participants would typically perform independently if not for a disability, including hands-on support, cueing, and standby assistance, as appropriate. Services also include direct, in-person supervision, monitoring, and redirection to help prevent harm and respond to health and safety needs (for example, when an individual is at risk of wandering or engaging in unsafe behaviors). Residential Support Services are intended to be provided solely in the assisted living residence, as authorized and described in the individual’s person-centered care plan.

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

Residential Support Services will be reimbursed on a monthly per diem basis. If an individual does not reside in the assisted living setting for the full month, the monthly rate will be prorated based on billable resident days. The daily rate is calculated by dividing the monthly rate by the number of days in the month; the monthly payment equals the daily rate multiplied by the number of billable resident days (i.e., Monthly payment = (Monthly rate ÷ days in month) × billable resident days). The day of admission and the day of discharge are billable days when the individual resides in the assisted living setting on those days. Days the individual is absent from the assisted living residence for a full 24-hour period (midnight to midnight) are not billable. The provision of Residential Support Services must be authorized by DPHSS and delivered as described in the individual’s person-centered care plan. Providers may bill a maximum of 12 months per year

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

- Participant-directed as specified in Appendix E
- Provider managed
- Remote/via Telehealth

**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	Enrolled Medicaid provider agency licensed to operate pursuant to code and regulations

**Appendix C: Participant Services**

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

**Service Type:** Other Service  
**Service Name:** Residential Support Services

**Provider Category:**

Agency

**Provider Type:**

Enrolled Medicaid provider agency licensed to operate pursuant to code and regulations

**Provider Qualifications**

**License (specify):**

N/A

**Certificate (specify):**

N/A

**Other Standard (specify):**

Residential Support Services providers must be trained to deliver services pursuant to DPHSS training standards. In addition to standard training requirements, personal care service providers must also be trained on the individual’s unique needs and support preferences. Provider agencies delivering Residential Support Services must conduct required background checks of all staff working directly with waiver participants upon hire and annually thereafter.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DPHSS

**Frequency of Verification:**

Initially upon and enrollment and annually thereafter. Additional verifications may occur more often as needed and determined by DPHSS

### 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:**

Respite

**HCBS Taxonomy:**

**Category 1:**

09 Caregiver Support

**Sub-Category 1:**

09012 respite, in-home

**Category 2:**

**Sub-Category 2:**

09 Caregiver Support

09011 respite, out-of-home

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

**Service Definition (Scope):**

Respite services are provided to support an individual on a short-term basis in the absence of a support provider or due to the need to give the primary caregiver or support provider a break. Respite services are only allowable for participants who live in their own home or a family home, and respite services may only be provided in the individual’s residence or a designated senior center during normal business hours. Respite may be provided by a relative or family member, as long as the relative or family member does not live in the participant’s home.

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

Respite may only be funded through the waiver when the services are not covered by a responsible third party, such as Medicare or private insurance. Room and board costs are excluded from the respite reimbursement rate. Respite services cannot be provided at the same time as Home-Based Supports services or Residential Supports services. The amount, frequency, and duration of the respite service is based on the participant’s needs as identified and described in the individual’s person-centered plan of care.

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

- Participant-directed as specified in Appendix E
- Provider managed
- Remote/via Telehealth

**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	Medicaid-enrolled provider agency

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Medicaid-enrolled provider agency

**Provider Qualifications**

**License (specify):**

N/A

**Certificate (specify):**

N/A

**Other Standard (specify):**

Provider agency enrolled as a Medicaid provider; home health agency enrolled as a Medicaid provider

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DPHSS

**Frequency of Verification:**

Initially upon enrollment and annually thereafter. Verification may occur more often as needed and determined by DPHSS Respite

**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:**

[Empty text box]

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:**

[Empty text box]

**HCBS Taxonomy:**

**Category 1:**

[Empty text box]

**Sub-Category 1:**

[Empty text box]

**Category 2:**

[Empty text box]

**Sub-Category 2:**

[Empty text box]

**Category 3:**

[Empty text box]

**Sub-Category 3:**

[Empty text box]

**Category 4:**

[Empty text box]

**Sub-Category 4:**

[Empty text box]

**Service Definition (Scope):**

[Empty text box]

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

[Empty text box]

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed
- Remote/via Telehealth

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	Enrolled Medicaid Provider Agency

### Appendix C: Participant Services

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

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

### 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:**

Therapeutic Support Services

**HCBS Taxonomy:**

**Category 1:**

10 Other Mental Health and Behavioral Services

**Sub-Category 1:**

10090 other mental health and behavioral services

**Category 2:**

10 Other Mental Health and Behavioral Services

**Sub-Category 2:**

10050 peer specialist

**Category 3:**

10 Other Mental Health and Behavioral Services

**Sub-Category 3:**

10070 psychosocial rehabilitation

**Category 4:**

10 Other Mental Health and Behavioral Services

**Sub-Category 4:**

10040 behavior support

**Service Definition (Scope):**

Therapeutic support services are designed to assist participants in improving functioning and independence, so they can successfully integrate into their communities, families, and social lives. Services may include the completion of a behavioral/mental health assessment, counseling and related services, the development of a personalized therapeutic support plan, and training provided to the individual, support staff, and family members. Services may also include consultation with other support and service providers, monitoring of the therapeutic support plan, and revisions to the plan as needed. This service may be delivered in the participant’s residence or any community setting the individual prefers. Therapeutic support services are provided by trained professionals and paraprofessionals, including psychologists, social workers, licensed counselors, peer support specialists, behavior support professionals, and others authorized by DPHSS. Unlicensed providers of this service must be under the supervision of a licensed practitioner.

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

Similar services to the therapeutic support service may be available under the Medicaid State plan. Therapeutic support services may only be provided when Medicaid State plan services are unavailable or insufficient to meet the individual needs of the participant. In addition, therapeutic support services may only be funded through the waiver when the service is not covered by a responsible third party, such as state plan, Medicare or other private insurance. This may be because insurance coverage limits have been reached, the service is not covered, or the available provider does not have the expertise or experience to support the unique needs of the individual.

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

- Participant-directed as specified in Appendix E
- Provider managed
- Remote/via Telehealth

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

<b>Provider Category</b>	<b>Provider Type Title</b>
Agency	Enrolled Medicaid Provider Agency

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Therapeutic Support Services**

**Provider Category:**

Agency

**Provider Type:**

Enrolled Medicaid Provider Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Enrolled Medicaid provider employing staff with training and qualifications sufficient to deliver the therapeutic support service; independent licensed psychologist enrolled as a Medicaid provider; independent social worker enrolled as a Medicaid provider; licensed professional counselor enrolled as a Medicaid provider; Medicaid-enrolled home health agency.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DPHSS

**Frequency of Verification:**

Initially upon enrollment and annually thereafter. Verification may occur more often as needed and determined by DPHSS

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Transition Assistance

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

16 Community Transition Services

16010 community transition services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

**Service Definition (Scope):**

Transitional assistance provides direct financial support toward expenses for individuals transitioning from an institutional setting or other unstable living arrangement to their own home or a family member’s home where the person is responsible for their own living expenses. This may be used to pay the necessary expenses for an individual to establish their basic living arrangement and to move into that arrangement.

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

Examples of allowable expenses include: essential furnishings and home setup supplies, such as a bed, a table, chairs, and food preparation items; moving expenses; required security deposits; setup fees or deposits for utility or service access for telephone, electricity, and heating; and services necessary for the participant's health and safety, such as one-time deep cleaning, hazard abatement, pest eradication, and allergen control. Transitional assistance may not be used to pay for regular utility charges or household items that are intended solely for recreational purposes or convenience.

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

- Participant-directed as specified in Appendix E
- Provider managed
- Remote/via Telehealth

**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	Independent vendors, landlords, utility companies, retail establishments

**Appendix C: Participant Services**

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

Service Type: Other Service

Service Name: Transition Assistance

**Provider Category:**

Individual

**Provider Type:**

Independent vendors, landlords, utility companies, retail establishments

**Provider Qualifications**

License (specify):

N/A

**Certificate (specify):**

N/A

**Other Standard (specify):**

Independent vendors, landlords, utility companies, retail establishments

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DPHSS

**Frequency of Verification:**

Initially upon request for funding and annually thereafter. Verification may occur more often as needed and determined by DPHSS

**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:**

Vehicle Modifications

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14020 home and/or vehicle accessibility adaptations

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Vehicle modifications are modifications or alterations to an automobile that is the participant’s primary means of transportation and designed to meet the unique needs of the participant. Vehicle modifications must be described in the person-centered plan of care and assessed as necessary to help ensure the health, safety, and welfare of the participant, as well as support the individual to participate in their community with greater independence. Vehicle modifications may not be reimbursed for modifications or improvements to the vehicle that are of general use and not directly related to the unique health and support needs of the participant. In addition, routine maintenance and upkeep of

a vehicle, including warranties, are not permitted.

Examples of vehicle modifications that may be funded through the waiver include:

- o Vehicular lifts
- o Portable ramps when the sole purpose of the ramp is for the participant to access the vehicle
- o Interior alterations to seats, head and leg rests, and belts
- o Customized devices necessary for the participant to be transported safely in the community, including tie-downs and wheelchair docking systems
- o Driver control devices, including hand controls and pedal adjusters
- o Raising the roof or lowering the floor to accommodate wheelchairs
- o The vehicle cannot be more than 10 calendar years old and must have less than 75,000 miles for vehicle modification requests over \$5,000

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

Vehicle modifications must meet all applicable inspection and registration standards and may be funded through the waiver only when not covered by Medicare, private insurance, or other payors. Service limits apply, to be determined by DPHSS. Modifications must be supported by an independent evaluation conducted by an appropriately licensed professional and are not reimbursable if completed during institutionalization until the participant transitions to the community.

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

- Participant-directed as specified in Appendix E
- Provider managed
- Remote/via Telehealth

**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	Vehicle modifications or repair business licensed to operate on Guam

**Appendix C: Participant Services**

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

**Service Type:** Other Service  
**Service Name:** Vehicle Modifications

**Provider Category:**

Individual

**Provider Type:**

Vehicle modifications or repair business licensed to operate on Guam

**Provider Qualifications**

**License** (specify):

Vehicle repair business licensed and permitted to operate on Guam and in compliance with all related standards, regulations, and policies

**Certificate** (specify):

N/A

**Other Standard** (specify):

N/A

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DPHSS
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**Frequency of Verification:**

Initially upon enrollment and annually thereafter. Verification may occur more often as needed and determined by DPHSS Respite
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## Appendix C: Participant Services

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### 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 section 1915(i) of the Act (HCBS as a State Plan Option).** Complete item C-1-c.
- As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** Complete item C-1-c.
- As an administrative activity.** Complete item C-1-c.
- As a primary care case management system service under a concurrent managed care authority.** Complete item C-1-c.
- As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** 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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

Case Management Agencies must be enrolled as a Medicaid provider and obtain all licenses necessary to operate a business on Guam in accordance with local rules and regulations.

A Case Management Agency must employ staff with appropriate experience and knowledge regarding person-centered thinking, planning, and systems. Case managers may have a bachelor’s degree in social work or other human service areas of study. In lieu of a bachelor’s degree, case managers may have substituted experience working directly with individuals with disabilities.

Case Management Agencies must have mandatory annual training programs for all case management staff. Areas of required training include person-centered thinking and planning, HCBS Settings Rule requirements, program participants’ rights and responsibilities, service documentation, identifying, reporting, and responding to allegations of abuse, neglect, or exploitation, and reporting and responding to complaints and grievances.

DPHSS will partner with internal and external stakeholders, including the University of Guam’s Center for Excellence in Developmental Disabilities Education, Research, and Service (CEDDERS), to develop and implement training programs, as well as any provider qualification or certification requirements, as needed. CEDDERS’ core functions include interdisciplinary training, services, supports, research, and community engagement and education responsive to Guam’s community needs. CEDDERS also operates an Advisory Council to inform and engage a broad range of community stakeholders, including providers of services to people with disabilities.

Case Management Agencies must have documented contingency plans to ensure continuity of services in the event of a disaster or emergency.

**d. Remote/Telehealth Delivery of Waiver Services.** Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

**No services selected for remote delivery**

## 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):

- All positions that interact directly with waiver participants, including case managers, direct care staff, janitorial or support staff, and licensed clinical staff, will have or obtain two background checks prior to delivering services to waiver participants:
  - o A territorial background check (“Police Clearance”) from the Guam Police Department that will reflect whether the applicant/employee has a record of criminal conviction(s) subject to Guam law
  - o A federal background check (“Identity History Summary Check”) from the Federal Bureau of Investigation
- Administrative positions that do not directly interact with waiver participants will be subject to any background investigation policies held by their employer.

**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; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. 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):

## Appendix C: Participant Services

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

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

## Appendix C: Participant Services

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

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is "*extraordinary care*", exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring 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 types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

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

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

Oversight and payment verification procedures:  
 DPHSS requires all enrolled providers to perform routine monitoring of services when delivered by a relative. Monitoring includes submission of a monthly timesheet, submission of service documentation, and review and approval of service documentation prior to submission of claims for payment. DPHSS also requires immediate reporting to DPHSS of any concerns regarding the health, safety, and welfare of a participant receiving services from a relative and/or legal guardian, as well as reporting any concern regarding the integrity and validity of service delivery documentation. DPHSS may conduct periodic random reviews to help ensure payments are made only for services rendered by paid family members.

- **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:

DPHSS will employ standard strategies to ensure that all willing and qualified providers have the opportunity to enroll as waiver service providers. These strategies include public notice, providing information through DPHSS and partner agency channels about the availability of provider enrollment, provider qualifications, and enrollment instructions; non-discriminatory enrollment standards, applying standardized criteria to all provider applicants; and a fair hearing process which allows any adverse provider enrollment determination to be appealed with clear instructions of the process for requesting a hearing, appeal timelines, and contact information.

DPHSS provides for the continuous open enrollment of waiver service providers and provides access to information regarding the requirements and procedures to enroll as waiver providers. DPHSS offers paper-based enrollments and online, portal-based re-enrollments for providers and telephonic customer support to prospective providers.

**g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act.** Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one:*

- No, the state does not choose the option to provide HCBS in acute care hospitals.
- Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions. By checking the boxes below, the state assures:
  - The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;
  - The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;
  - The HCBS must be identified in the individual's person-centered service plan; and
  - The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.

*And specify:* (a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting; (b) How the 1915(c) HCBS will assist the individual in returning to the community; and (c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.

## 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

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

##### i. Sub-Assurances:

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

##### Performance Measures

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

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

##### Performance Measure:

**All providers meet training, licensure, and/or certification requirements. Numerator: Number of providers reviewed with documentation evidencing required training, licensure, and/or certification requirements Denominator: Total number of providers' qualifications records reviewed**

**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 type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**b. Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

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

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

**Performance Measure:**

**All non-licensed/non-certified providers have completed all initial and annual training requirements. Numerator: Number of non-licensed/non-certified providers with documentation of all training requirements Denominator: Total number of non-licensed/non-certified provider training records reviewed**

**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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

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

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

- 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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

- When an individual problem is identified (e.g., missing background checks or provider training) by a case manager, provider agency staff, or by DPHSS waiver operations staff, the responsible individual logs a corrective action with their supervisor and with the DPHSS QA Unit within 10 business days.
- Corrective actions may include providing training, licensing, or other certification documentation, updating documentation, , revising service plans, suspending non-compliant providers, or updating processes that could have led to risks or errors.
- DPHSS waiver operations staff review and approve plans of correction to ensure compliance with waiver requirements.
- All actions are logged in the DPHSS tracking system, including date of discovery, corrective steps taken, and resolution date, and retained for CMS or other regulatory review.
- DPHSS operations staff will review problems and corrective actions initially on a monthly basis as waiver operations begin and then on a quarterly basis to identify and evaluate systemic issues and implement preventive policies and practices.
- DPHSS partners and stakeholders will receive briefings on systemic issues for collaborative mitigation, particularly in instances where the work of external entities (e.g., referring internal DPHSS agencies) is implicated in the problem,

corrective action, or preventive policy and practice.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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 Qualified Providers that are currently non-operational.

- No**
- Yes**

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

**Appendix C: Participant Services**

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**C-3: Waiver Services Specifications**

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

**Appendix C: Participant Services**

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**C-4: Additional Limits on Amount of Waiver Services**

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

- Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable -** The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based

on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. *(check each that applies)*

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

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

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

- Other Type of Limit.** The state employs another type of limit.  
*Describe the limit and furnish the information specified above.*

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are received. *(Specify and describe the types of settings in which waiver services are received.)*

## Assisted Living Residence

DPHSS renovated an assisted living residential site to serve the target population supported in this Kumunidât Diniseha: Community of Hope program. The assisted living residence is centrally located and fully integrated into the greater community. The residence is located near a church, a Mayor's Council of Guam Senior Center, shopping, and recreational activities. The assisted living residence is also located in close proximity to a hospital and other medical service providers, as well as DPHSS headquarters. The assisted living residence is fully accessible, and each room is designed to provide privacy and ensure residents are able to live and engage with their community of choice as independently as possible.

## Adult Day Services Sites

The Mayor's Council of Guam operates Senior Centers in each of the island's seven villages. Each Senior Center is fully integrated into the community and co-located with other recreational sites such as baseball fields, basketball courts and communal spaces

## Community Homes

Individuals may receive the waiver services of their choice in their own home or family home.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

DPHSS partnered with Guam Legal Services Corporation (GLSC) throughout the process of purchasing and renovating of the assisted living residence to ensure that the setting meets all federal HCBS requirements. GLSC will continue to monitor service delivery at all HCBS program sites on a regular basis to monitor for ongoing compliance with federal HCBS requirements, as well as adherence to the Permanent Injunction.

All HCBS settings must comply with the HCBS Settings Rule (42 CFR § 441.530), and the following characteristics must be present in each setting where HCBS are provided for the setting to be considered home and community based:

- o It is integrated in and supports full access to the greater community.
- o It is selected by the individual from a variety of settings options.
- o It optimizes autonomy and independence in making life choices.
- o It facilitates individual choice in selecting both services and service providers.
- o It ensures individuals' rights of privacy, dignity, respect, and freedom from coercion and restraint.

DPHSS will utilize the following approaches to assess initial and ongoing compliance with the HCBS Settings Rule:

- o Self-assessments (through provider self-survey).
- o On-site assessment process and heightened scrutiny on-site reviews.
- o Waiver program policies and HCBS Settings Rule processes.
- o Quality assurance and technical assistance for providers in response to identification of noncompliance in any HCBS settings.
- o Routine monitoring of all provider-owned and provider-controlled settings by GLSC.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

- The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**
- The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. (see Appendix D-1-d-ii)**
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**
- Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**
- Facilitates individual choice regarding services and supports, and who provides them.**

- Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.

**Provider-owned or controlled residential settings.** (Specify whether the waiver includes provider-owned or controlled settings.)

- No, the waiver does not include provider-owned or controlled settings.
- Yes, the waiver includes provider-owned or controlled settings. (By checking each box below, the state assures that each setting, in addition to meeting the above requirements, will meet the following additional conditions):
- The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
  - Each individual has privacy in their sleeping or living unit:
    - Units have entrance doors lockable by the individual.
    - Only appropriate staff have keys to unit entrance doors.
    - Individuals sharing units have a choice of roommates in that setting.
    - Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
  - Individuals have the freedom and support to control their own schedules and activities.
  - Individuals have access to food at any time.
  - Individuals are able to have visitors of their choosing at any time.
  - The setting is physically accessible to the individual.
  - Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan (see Appendix D-1-d-ii of this waiver application).

## Appendix D: Participant-Centered Planning and Service Delivery

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

**State Participant-Centered Service Plan Title:**

Person-Centered Plan of Care

**a. Responsibility for Service Plan Development.** Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. (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:

1. A bachelor's degree or associate degree from an accredited college or university OR at least four years of full-time experience providing person-centered care and support to individuals with disabilities; case managers without a recognized degree are required to work under the supervision of a licensed or certified case manager during their first two years of employment as a waiver case manager
2. Training in person-centered planning; participant rights; abuse, neglect, and exploitation (ANE) prevention and reporting; documentation and record-keeping; Health Insurance Portability and Accountability Act (HIPAA) compliance; diversity, equity, and inclusion; and trauma-informed services delivery
3. The case management agency and case manager must minimize any conflicts of interest , where possible, including:
  - a. Not related by blood or marriage to the participant or any person providing Medicaid reimbursed HCBS to the participant
  - b. Not authorized to make decisions on behalf of the participant,
  - c. Not financially responsible for the participant
  - d. Not sharing a residence with the participant, nor with any person providing Medicaid reimbursed HCBS to the participant

**Social Worker**

*Specify qualifications:*

**Other**

*Specify the individuals and their qualifications:*

## Appendix D: Participant-Centered Planning and Service Delivery

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

**b. Service Plan Development Safeguards.** Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *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. *Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

The geography and population of Guam are small. There is a high likelihood of participants, providers of waiver services, entities and people developing service plans, and case managers or their employers being related by blood or marriage. DPHSS ensures these conflicts are avoided when feasible and that declarations of potential or perceived conflicts of interest are documented when they are unavoidable because there is no other entity available to be responsible for the development of the service plan that does not have a potential conflict.

DPHSS will continuously monitor any provider delivering both case management and direct support services to ensure that no conflict of interest impacts the delivery or quality of services. If a conflict of interest is identified, DPHSS will direct the conflicted provider to take all necessary action to resolve the conflict. DPHSS will perform an extensive review to evaluate whether the specific conflict was resolved and that no other conflicts exist.

Case managers are responsible for ensuring participants are fully informed of all services available in the waiver and their right to choose from and among all willing and qualified providers that are part of the program's provider network, as well as documenting evidence of participant choice. Case managers are also responsible for providing participants with information and training on the process for selecting qualified providers of services during the development of their person-centered plan.

*(Complete only if the second option is selected)* The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

- Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- Direct oversight of the process or periodic evaluation by a state agency;**
- Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

All program participants will have their service plan developed through a person-centered planning process that includes informing the participant of their right to choose who is involved in the development of their plan. The participant's case manager will provide an in-depth explanation of the program, including all waiver and non-waiver services available, participant rights and responsibilities, and the array of available service providers (when possible). Waiver program participants are also informed of their right to choose between waiver services or institutional care and sign a Freedom of Choice form indicating their preference for community-based services.

Person-centered service planning is a process directed by the participant with long-term service and support needs. The participant has the authority to include a representative who is authorized to make personal decisions for the participant. The participant also has the authority to include family members, legal guardians, friends, caregivers, members of the person-centered planning team, and any others the participant or their representative wishes to include. The person-centered planning process helps to identify outcomes based on the participant's goals, interests, strengths, abilities, and preferences. The process assists the participant to articulate a plan for the future and helps determine the supports and services that the participant needs to achieve these outcomes. Resources such as the Department of Integrated Services for Individuals with Disabilities (DISID) "Eco Map" are used to identify the people, places, and community resources most important to the participant.

The case manager is responsible to include all of those elements in a unified person-centered plan of care that describes the services and supports, both formal and informal, that will be implemented to achieve the participant's preferred goals and outcomes. All service descriptions must also include the amount, frequency, and duration of each service needed to accomplish the participant's goals and preferred outcomes.

The person-centered care planning approach must provide the necessary level of support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions. The case manager must submit the person-centered plan of care to DPHSS to obtain approval and authorization of the plan.

## Appendix D: Participant-Centered Planning and Service Delivery

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

- d. i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

- (a) Waiver program case managers are responsible for the development of the person-centered plan of care in collaboration with the individual, their legal representative (if applicable), program service providers, and any person the individual chooses to include in the service planning process. The person-centered plan of care must be developed within the first 30 days of program enrollment. An interim person-centered plan of care may be developed prior to the individual's discharge from an institutional setting (when applicable) to help ensure that all necessary services are in place prior to their transition to a community setting.
- (b) In addition to the standardized functional assessment of need, the case manager is responsible for assessing the individual's needs, preferences, and goals using a set of supporting questions developed by DPHSS. These questions assist the individual in providing their case manager and person-centered care planning team meaningful information about the individual's priorities. Through the assessment and planning process, individual's healthcare needs are identified and addressed. The case manager is responsible for assisting in scheduling and/or referral for evaluations, routine health care, medical equipment, and medical appointments when the individual requests support.
- (c) Each program participant will be provided with a full list and explanation of each service available in the waiver, including service providers available to deliver each service, at their initial meeting with the case manager.
- (d) Program participants may be eligible for additional community-based programs and services. The waiver case manager is responsible for identifying state plan or other community-based programs that the individual may benefit from and coordinating any referrals or evaluations.
- (e) The case manager will coordinate care planning with other programs and services and help ensure that the individual's entire system of support and services is reflected in the person-centered plan of care. Representatives from other programs may also participate in the waiver care planning team at the individual's request.
- (f) The case manager is responsible for monitoring implementation of the plan. The case manager will conduct face-to-face meetings with the individual at least monthly, or more often as needed, to monitor implementation and identify when needs or circumstances have changed that may warrant a revision to the person-centered plan of care. Provider agencies are also responsible for monitoring the individual's service plan to ensure that services are being delivered as authorized. DPHSS will also conduct periodic reviews of service utilization to assess whether services are being delivered in the amount, frequency and scope as approved in the person-centered plan of care.
- (g) As previously stated, the person-centered plan of care will be reviewed and revised on a quarterly basis during the individual's first year of program enrollment, then bi-annually thereafter. The case manager will monitor any changes in the individual's needs, preferences, goals, and/or circumstances during monthly face-to-face meetings. In addition, the individual may request a review and update of the person-centered plan of care at any time.
- (h) The individual, their family, and other chosen supports work together to identify and address the unique strength, capacities, goals, preferences, needs and chosen outcomes through the development of the person-centered plan of care. This is accomplished by empowering the individual to lead the care planning meeting by choosing who participates, when and where the meeting occurs, and what topics are most important for the care planning team to address. The individual, and their legal representative when applicable, must review and approve the plan of care and confirm that it accurately reflects their preferences and choices.
- (i) The individual, their legal representative, and all members of the person-centered care planning team must sign the person-centered plan of care before services may be authorized. If any member of the care planning team disagrees with the plan of care, that disagreement must be documented within the plan of care.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

- The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**
- For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**
  - A specific and individualized assessed need for the modification.**
  - Positive interventions and supports used prior to any modifications to the person-centered service plan.**
  - Less intrusive methods of meeting the need that have been tried but did not work.**
  - A clear description of the condition that is directly proportionate to the specific assessed need.**
  - Regular collection and review of data to measure the ongoing effectiveness of the modification.**
  - Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**

- Informed consent of the individual.**
- An assurance that interventions and supports will cause no harm to the individual.**

## 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 will conduct an initial assessment of risks by reviewing the standardized functional assessment of need. Further risk identification will occur during the case manager's initial face-to-face meeting with the participant and members of the individual's chosen person-centered care planning team. Additional risks may be identified by the individual or other members of the planning team during development of the initial person-centered plan of care. The participant and other individuals involved in the development will identify strategies for mitigation, facilitated by the case manager. Identification of breakdowns or failures in the service plan or the delivery of the services will trigger the need for the person-centered planning team to meet and identify actions needed to implement mitigation strategies, including alternate services, supports, or settings.

## 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.

Despite the geographic and population constraints on Guam, DPHSS will make every effort to enroll all able, willing, and qualified waiver service providers. DPHSS will provide program participants with a complete list of available waiver service providers in the format of their choice (paper or electronic form, upon request.) The list of providers will include the following information where available:

- The names, addresses, and telephone numbers of program providers
- Identification of the services provided by each enrolled program provider
- Experience or specialized expertise in serving individuals with particular conditions, if applicable

The case manager is also responsible for ensuring that participants are fully informed of their right to choose service providers before services begin, at each reevaluation, and at any time during the year when a participant requests a change of providers. The case manager is responsible for documenting the participant's informed choice of providers.

## 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):

All person-centered plans of care will be submitted to DPHSS for review and approval. DPHSS will review all person-centered plans of care developed for participants in the waiver program to verify that each plan is complete, reflects the participant's assessed needs and preferences, identifies waiver and non-waiver supports, and authorizes only those services that are necessary to meet the individual's unique goals and objectives, and consistent with waiver requirements. DPHSS is the sole entity responsible for the review and approval of all person-centered plans of care under the waiver; services may not be initiated, continued, or reimbursed until the plan has been reviewed and approved by DPHSS.

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, when the individual's circumstances or needs change significantly, or at the request of the individual, 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:

[Empty rectangular box for specifying 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):

- [x] Medicaid agency
[ ] Operating agency
[ ] Case manager
[ ] Other

Specify:

[Empty rectangular box for specifying maintenance details]

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, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

DPHSS waiver and quality staff maintain oversight responsibility for the implementation of the person-centered plan of care, including access to waiver and non-waiver services and support, the quality of waiver service delivery, and the health, safety, and welfare of program participants. DPHSS will monitor waiver service utilization on a routine basis to identify and address any service gaps and help to ensure effective program operations. DPHSS operations and quality staff will also conduct routine provider reviews to assess general provider operations and compliance with program rules and procedures, as well as evaluate individual person-centered plans to ensure services are delivered in the amount, frequency, and duration to achieve the individual participant’s program goals and outcomes. Case managers will also monitor service plan implementation during routine case management visits, confirming service delivery according to the service plan, including amount, frequency, and duration. A standardized provider self-review tool will be developed for collecting information about implementation of the service plan and delivery of services. Case managers are also required to review and update, if necessary, person-centered plans of care at least quarterly during the individual’s first year of participation in the waiver following each re-assessment for continuing eligibility. Case managers must also review and update the person-centered plan of care more frequently if there is a change in the participant’s status or circumstance, or at any time at the participant’s request.

The DPHSS-established frequency of monitoring and evaluation will compared to the frequency followed by the case managers. The monitoring and evaluation plan will contain the activities required for monitoring, the measures for reporting successful execution of the service plan according to the services and goals of the plan, and criteria or events that should trigger a risk mitigation strategy, alternate services, providers, or settings, and/or revisions to update the service plan.

In addition to monitoring and reporting by case managers, DPHSS business units and staff involved in audit and review of HCBS provider billing for alignment with the service plan and claims data will be used for routine quality review. New providers will be reviewed within their first 90 days of operation following provider enrollment and annually thereafter. DPHSS may also conduct provider reviews more frequently in response to complaints or concerns regarding person-centered practices and planning.

**b. Monitoring Safeguard.** Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

*(Complete only if the second option is selected)* The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

- Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- Direct oversight of the process or periodic evaluation by a state agency;**
- Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

- Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

## 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**

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

All participants' person-centered plans are designed to meet the individual's unique needs, capabilities, and preferred outcomes. **Nominator: Number of waiver participant person-centered plans of care that are designed to meet the individual's unique needs, capabilities, and preferred outcomes** **Denominator: Total number of waiver participant person-centered plans reviewed**

**Data Source** (Select one):

**Provider performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <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 checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

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

**Data Aggregation and Analysis:**

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

**b. Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.**

**Performance Measures**

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

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

**Performance Measure:**

**Person-centered plans of care are reviewed and revised in response to participants’ changing needs. Numerator: Number of person-centered plans of care revised following a change in participants’ needs Denominator: Total number of person-centered plans reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input 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 type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>

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

**Performance Measures**

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

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

**Performance Measure:**

**Numerator:** Number of participant records reviewed that indicate that services are delivered in the amount, frequency, and duration identified in the person-centered plan of care  
**Denominator:** Total number of program participant records reviewed to evaluate service delivery as specified in the person-centered plan of care

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**d. Sub-assurance: Participants are afforded choice between/among waiver services and providers.**

**Performance Measures**

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

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

**Performance Measure:**

**All participants are offered choice between in-patient/institutional settings and home and community-based settings. Numerator: Number of participants with documentation verifying that they were offered choice between in-patient/institutional settings and home and community-based settings. Denominator: Number of participant records reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>

<b>Agency</b>		
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
	Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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

**Performance Measures**

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

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

**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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

DPHSS retains ultimate responsibility for monitoring the implementation of person-centered plans of care for all waiver participants, including access to both waiver and non-waiver services and supports. Once services are authorized, DPHSS will monitor the implementation of services on a routine basis to confirm that services are initiated in a timely manner and are being provided in accordance with the participant’s preferences as identified in the person-centered plan of care.

The case manager and service provider agencies are also responsible for ongoing monitoring of the implementation of person-centered plans of care. Both individual and systemic issues related to the implementation of person-centered plans of care will be monitored by all responsible entities through provider self-reviews, and any issues identified will be reported to DPHSS for remediation.

DPHSS will also conduct initial and ongoing provider quality reviews to assess compliance with person-centered planning requirements. Any instances of noncompliance will be addressed directly with the provider through technical assistance and corrective action, as needed. DPHSS will collect quality review data to analyze findings, identify any systemic deficiencies, and implement remediation activities, as warranted. Data regarding these findings will be shared with internal and external stakeholders for feedback and collaborative efforts to improve program operations.

DPHSS also partners with GLSC to conduct routine monitoring of all aspects of HCBS provided on Guam. DPHSS will continue to leverage this partnership in the operations of the program and regularly coordinate with GLSC to proactively identify and respond to any areas of concern.

**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 checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:  <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:  <input type="text"/>

**c. Timelines**

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- No
- Yes

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

**Appendix E: Participant Direction of Services**

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**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.*

**Appendix E: Participant Direction of Services**

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**E-1: Overview (1 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (2 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (3 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (4 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (5 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (6 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (7 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (8 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (9 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (10 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (11 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (12 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

**E-1: Overview (13 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

**Appendix E: Participant Direction of Services**

**E-2: Opportunities for Participant Direction (1 of 6)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

**Appendix E: Participant Direction of Services**

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

**Appendix E: Participant Direction of Services**

**E-2: Opportunities for Participant-Direction (3 of 6)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

**Appendix E: Participant Direction of Services**

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

**Appendix E: Participant Direction of Services**

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

**Appendix E: Participant Direction of Services**

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

**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.

Per 42 CFR Part 431, Subpart E, waiver applicants are provided with the following:

- Written notification of the findings of the standardized functional assessment of need and eligibility determination, along with a notification of their right to a fair hearing in the case of an adverse determination
- Contact information of Medicaid agency eligibility and enrollment specialists, including those responsible for the standardized functional assessment of need, in case to the applicants wants to request additional information regarding eligibility determination and enrollment
- When possible, contact information for community legal services such as GLCS and the Public Defender Service Corporation, as needed

## 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**

• **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.

**Do not complete this item.**

## 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**

• **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

Pursuant to 10 GCA Ch.2 §2915, DPHSS operates a grievance and complaint system that includes the following processes:

- 1) The individual pursuing a complaint or grievance has the right to have another person of their choosing assist with the complaint or grievance.
- 2) If the individual chooses to pursue a formal hearing, the individual will be granted a hearing conducted by an impartial hearing officer.
- 3) A person pursuing a formal hearing will be provided a written notice including the date, time, and place of the hearing at least 10 working days in advance of the hearing. The written notice must:
  - a. Inform claimant of the time, date, and place of the hearing
  - b. Advise the individual or their representative of the name, address, and phone number of the person to notify in the event that it is not possible for the claimant to attend the scheduled hearing
  - c. Specify that the agency will dismiss the hearing request if the claimant or the claimant's representative fails to appear for the hearing without good cause
  - d. Explain that the claimant or the claimant's representative may examine the case file prior to the hearing
  - e. Advise the claimant of the possible availability of legal services from the Public Defender Service Corporation
- 4) The hearing shall be conducted by an attorney or an arbitrator who does not have any personal stake or involvement in the case and was not directly involved in the initial determination of the action that is being contested. Responsibilities of the hearing officer shall include:
  - a. Administer required oaths or affirmations
  - b. Ensure all relevant issues are considered
  - c. Request, receive, and make part of record all evidence determined necessary to decide the issues being raised
  - d. Regulate the conduct and course of the hearing, consistent with due process to ensure an orderly hearing
- 5) The individual shall be notified in writing of the decision and the reasons for the decision.
- 6) After a hearing decision, which upholds the agency action, the claimant shall be notified of the right to pursue judicial review of the decision.
  - i. A grievance or appeal shall be filed in writing and received by the Administrator no later than 60 days after the date of the adverse action, decision, or policy implementation being grieved. If a grievance or appeal is not filed within the time required by this section, the initial decision shall be considered the final decision. The hearing officer shall render a decision on each grievance no later than 90 days from the date the Administrator receives the request for a hearing, unless the hearing is postponed or rescheduled at the request of all of the parties, or the hearing officer orders a further extension.
  - ii. If a person is dissatisfied with a final decision on a grievance properly submitted and heard under the provisions of this Article, the person may file for judicial review under the provisions of the Administrative Adjudication Law.

- **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 the formal grievance and complaint system described above in F-3-b, DPHSS will accept complaints from participants, providers, families, and community members by phone and email. DPHSS operations staff will log complaints in a tracking system and acknowledge receipt within two business days. Staff will prioritize urgent issues (health/safety or service interruption) for action within 48 hours, with standard complaints resolved within 15 business days. Investigations will include record review and outreach to the complainant and provider. DPHSS will provide a written outcome to the complainant if appropriate, maintain complaint logs that state the findings, actions taken, and next steps, and track closure, trends, and corrective actions for continuous improvement.

## 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).

The Guam Annotated Code (Title 10, Chapter 2, Article 10) identifies and defines the following instances of ANE that require reporting to the DPHSS Bureau of Adult Protective Services (BAPS):

- “Elderly or adult with a disability abuse” means self-neglect or any one or more of the following acts inflicted on an elderly or adult with a disability by other than accidental means by another person: physical abuse, neglect, or abandonment
  - Abandonment
  - Bodily injury
  - Desertion
  - Emotional or psychological abuse
  - Financial or property exploitation
  - Neglect
  - Physical abuse
  - Physical harm
  - Self-neglect abuse
  - Serious abuse
  - Sexual abuse

Any person who, in the course of their employment, occupation, or professional practice, comes into contact with elderly adults or adults with disabilities and has actual knowledge or reasonable cause to believe that an elderly person or adult with a disability is suffering from or has died as a result of abuse as defined in § 2951 shall immediately make a verbal report of such information or cause a report to be made to the BAPS or its authorized agency and shall, within 48 hours, make a written report to the Bureau or its authorized agency. If a verbal report is made on a Friday, a written report will be made by the next workday.

People required to report abuse include, but are not limited to, physicians, medical interns, medical examiners, nurses, chiropractors, hospital personnel engaged in the admission, examination, care, or treatment of people, social workers, employees of nursing homes, senior citizen centers and adult day care facilities, police officers, probation officers, employees of homemaker and home health service agencies, emergency medical service (EMS) providers, non-emergency medical transport providers, medical and allied health care providers, banking or financial institution personnel, pension providers, and practicum students in the field of health and human services.

In addition to the instances of ANE enumerated below, providers are also required to document and report any medication administration that results in harm or potential of serious harm. DPHSS employs licensed nursing staff who will provide program oversight, including the administration of medication by program provider staff. DPHSS nursing staff will conduct routine review of medication administration records to identify any medication errors and provide technical assistance, training, and general oversight of medication administration at program service locations.

Program providers are also required to document and report any unauthorized use of restraint, any injury resulting from the use of restraint, any unexpected or suspicious death, and/or program participant interaction with law enforcement that results in detention or custody. DPHSS will monitor all reported incidents and take appropriate action, including technical assistance, investigative or “special” reviews, corrective action, and possible contract action (when deemed necessary by DPHSS).

- 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.

Individuals will receive clear information about their right to be free from abuse, neglect, and exploitation (ANE) through multiple channels, including written materials provided at enrollment, verbal explanation during initial functional assessment of need, and ongoing reminders will be posted in common areas of the assisted living residence and all program sites of service. DPHSS will require that staff review these rights with each individual upon admission and annually thereafter, documenting the discussion in the person's record. Educational materials will define ANE, outline examples, and explain how to report concerns confidentially via phone, email, or in person to DPHSS. Additionally, individuals will be informed that retaliation for reporting is prohibited and that they have access to advocacy resources for support in exercising these rights.

**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.

BAPS is responsible for receiving and investigating allegations of ANE. BAPS' mission is to develop and maintain a coordinated system of protective services to intervene or prevent further abuse to seniors and adults with a disability; to provide or arrange for and monitor the provision of services necessary to safeguard and ensure the client's well-being; and to preserve and stabilize family life wherever appropriate.

BAPS is mandated to receive and investigate all reports of abuses against the elderly or adults with a disability; these specifically include, but are not limited to, reports of abuse in facilities operated by public or private agencies and in private residences. The types of abuse reportable to BAPS include: abandonment, physical abuse, emotional or psychological abuse, financial or property exploitation, neglect, self-neglect, or sexual abuse. Further, the Bureau provides outreach, education, monitoring, and advocacy for vulnerable elders and adults with disabilities. BAPS also provides education, monitoring, and advocacy for vulnerable elders and adults with disabilities.

BAPS is a bureau within DPHSS. BAPS will routinely share reports regarding the findings of all ANE investigations involving program participants. DPHSS and BAPS will develop processes and procedures to share data and information in a timely manner to help ensure the health, safety, and welfare of program participants.

In addition to ANE, program providers are responsible for monitoring, reporting, and responding to other critical events or incidents that pose a significant risk of harm to program participants. These types of incidents include:

- o Misuse or unauthorized use of restrictive interventions or seclusion
- o A medication error resulting in a telephone call to, or a consultation with, a poison control center, an emergency department visit, an urgent care visit, a hospitalization, or death
- o An unexplained or unanticipated death, including, but not limited to, a death caused by abuse or neglect

Waiver providers are required to report all critical incidents involving waiver participants to DPHSS program operations staff immediately or, at a minimum, within 24 hours of discovery. Waiver providers are also required to document all critical incidents and take all measures necessary to assure the individual's safety. Upon DPHSS direction, program providers may be required to conduct an internal review and investigation of the incident and share findings with DPHSS within a defined time frame. An investigation includes taking the steps necessary to determine if a critical incident has occurred, if suspected abuse, neglect, abandonment, or exploitation requiring protective services is involved, what actions are needed to protect the health and welfare of participants, and what actions are needed to mitigate future incidents. DPHSS, at its discretion, may conduct a targeted provider review and investigation of critical incidents to address individual incidents, as well as identify any existing practice that could place participants at risk for future critical incidents.

**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.

DPHSS retains responsibility for oversight of critical incidents and events. DPHSS will routinely review reports regarding critical incidents and events to track and trend this data. DPHSS will work with program providers to ensure that participants’ health, safety, and welfare is protected. DPHSS and its Bureaus, including BAPS, will routinely meet to review individual incidents and systemic challenges and identify potential program changes that might be needed to minimize future incidents.

BAPS retains responsibilities for investigation and oversight of reports of ANE.

The findings of critical incident investigations will be shared with internal and external stakeholders on a quarterly basis to support efforts to remediate incidents and develop recommendations for quality improvement related to the occurrence of and response to critical incidents and events.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

**a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

- The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

- The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

**i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DPHSS will verify that waiver staff complete standardized de escalation and restraint training by requiring proof of certification during enrollment and ongoing monitoring. Any unauthorized use of restraint must be reported to DPHSS immediately or within one hour for rapid review and protective actions.

Restraint is defined in 10 GCA Ch. 82 as the following:

Restraint means the involuntary immobilization of a person through the use of chemical, mechanical or physical means.

(1) Chemical Restraint means a drug or medicine used as a restraint to control behavior or to restrict an individual’s freedom of movement that is not standard treatment for an individual’s medical or psychiatric condition.

(2) Mechanical restraint means the use of a mechanical device, material, or equipment attached or adjacent to the person’s body that he or she cannot easily remove and that restricts normal access to the person’s body.

(3) Physical restraint means the use of a physical hold to restrict freedom of movement of all or part of a person’s body to restrict normal access to the person’s body, which is used as a behavioral restraint

Contracts and/or regulations will explicitly define permitted restraint types, prerequisites (e.g., imminent risk and least restrictive alternative), staff training requirements and documentation, supervisory approvals, and consequences for noncompliance. Guam is under a Permanent Injunction with Guam Legal Services Corporation (GLSC) designated as an independent monitor for restraint use, including access to records, incident reviews, corrective action recommendations, and oversight.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DPHSS monitors the use of restrictive measures and interventions through required reporting of all instances of the use of restraints.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DPHSS monitors the use of restrictive measures and interventions through required reporting of all instances of the use of restraints.

### Appendix G: Participant Safeguards

#### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. (Select one):

- The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

- 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.

See response above for G-a-1

- 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:

See response above for G-a-ii

**Appendix G: Participant Safeguards**

**Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)**

- c. **Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

DPHSS is responsible for detecting the unauthorized use of restrictive interventions. This is achieved through regular health and wellness checks, as well as GLSC routine inspections of all HCBS program sites, including waiver service delivery sites. GLSC monitoring visits include document review and interviewing residents, participants, staff, and others regarding the use of restrictive practices, including restraints. In the event that the use of seclusion is alleged, DPHSS operations staff will take immediate action to review and respond to the allegation.

- **The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

**Appendix G: Participant Safeguards**

## Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

- No. This Appendix is not applicable** (do not complete the remaining items)
- Yes. This Appendix applies** (complete the remaining items)

- **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.

The assisted living residence will maintain a routine nursing presence with regular in-person supervision and virtual supervision available during regular working hours by phone, with available coverage documented and communicated to staff. Nursing staff will be responsible for secure storage (locked, temperature controlled), inventory control, and monitoring of all medications, including a weekly review of medication administration records to reconcile orders, identify errors or missed doses, and initiate corrective actions. For non-licensed staff delegated to conduct medication administration by a nurse, DPHSS will require training aligned with nursing regulations (e.g., medication safety, the five rights, infection control, parameters for administration of as needed (PRN) medications, and documentation), competency verification (skills check-offs and annual revalidation), and ongoing nurse supervision with documented spot checks. Delegation of medication by waiver RN staff is governed by 10 GCA Ch. 12 Article 3 known as the Nurse Practice Act. All licensed nursing staff will be responsible for compliance with the Nurse Practice Act in the provision of nursing services to DISEHA program participants.

**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.

Administration of medication to waiver participants must be performed in compliance with all local rules and regulations, including the Nurse Practice Act. DPHSS employs public health nurses that serve in DPHSS-funded community health clinics. DPHSS will leverage the public health nurses to provide additional oversight of nursing services delivered in program sites, including Residential Support Services delivered in the assisted living residence and Adult Day Services sites. Providers are required to document the administration of medication in the individual's medication administration record. Both waiver providers and DPHSS public health nurses are required to routinely review medication administration records. Any issues identified must be documented, and nursing staff must develop and implement a plan to correct issues related to medication administration errors, including enhanced staff training, oversight, and formal corrective action to ensure the health, safety, and welfare of waiver participants.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

**c. Medication Administration by Waiver Providers**

**i. Provider Administration of Medications.** *Select one:*

- Not applicable.** (do not complete the remaining items)

- **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*
- **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).

In accordance with the Nurse Practice Act, any unlicensed staff administering medications to program participants must be trained on the individual’s unique medical needs by licensed nursing staff. Unlicensed staff may only administer medications after successful completion of medication administration training provided by a licensed nurse. The training must include an observed skill assessment conducted by the licensed nurse delivering the training. The observed skill assessment must demonstrate that the unlicensed staff has the ability to follow medication administration procedures safely, correctly, and consistently.

- **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:

DPHSS

(b) Specify the types of medication errors that providers are required to *record*:

Any errors

(c) Specify the types of medication errors that providers must *report* to the state:

Any errors that lead to contact with poison control, consultation with a licensed medical professional, or any medication administration error resulting hospitalization, death, other adverse health outcome, or a substantial likelihood of harm.

- **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:

- **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.

DPHSS reviews and verifies the licensure of all nursing staff on a routine basis during provider quality reviews.

Any medication administration errors reported to DPHSS as described in G-3-c-ii will be reviewed by program operations staff. At its discretion, DPHSS may conduct on-site or desk reviews performed by DPHSS licensed nursing staff to investigate the medication error(s), identify systemic concerns regarding the administration of medication by unlicensed staff, provide technical assistance, and/or require corrective action. Any medication administration error resulting in harm may also be reported to BAPS if the instance is believed to constitute abuse or neglect. BAPS will be responsible

## 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 demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.*

**i. Sub-Assurances:**

**a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.**

**Performance Measures**

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

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

**Performance Measure:**

**People receiving services, or their legal representative are informed, in writing, how to report abuse, neglect, exploitation (ANE) or other critical incidents. Numerator: Number of files of people receiving services with signed documentation demonstrating receipt of written guidance regarding how to report ANE or other critical incidents. Denominator: Total number of files reviewed.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <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 checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input 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 type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. *Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

**Performance Measures**

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

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

**Performance Measure:**

**Instances of abuse, neglect, exploitation, or unexplained death are reported in a timely manner according to local rules and regulations. Numerator: Number of allegations of abuse, neglect, exploitation, or unexplained death that were reported within required timelines Denominator: Total number of allegations reviewed**

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input 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 checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

	<input type="checkbox"/> <b>Other</b> Specify:  <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	
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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"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:  <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:  <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>

**c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

**Performance Measures**

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

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

**Performance Measure:**

**Instances of restraint or seclusion are compliant with waiver policies and documented in the individual’s person-centered plan of care. Numerator: Number of restraints performed in compliance with approved restraint practices and documented in the individual’s person-centered plan Denominator: Total number of restraints reviewed**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input 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 checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input 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 checked="" type="checkbox"/> Quarterly

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**d. Sub-assurance:** *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

**Performance Measures**

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

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

**Performance Measure:**

**Medication errors are documented and reported in compliance with Diesha program rules. Numerator: Number of medication administration errors documented and reported correctly, including re-training of unlicensed staff when appropriate**  
**Denominator: Total number of medication administration errors reviewed**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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

**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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

- When an individual problem is identified (e.g., inappropriate use of seclusion or restraint or medication administration error resulting in harm) by a provider, case manager, supervisor, family member, or any other entity, a supervisor is immediately notified and a corrective action plan is logged within two business days.
- Corrective actions may include reporting behavior to law enforcement, suspending non-compliant providers pending investigation, and updating any processes that could have contributed to the issue.
- DPHSS operations staff review and approve corrections to ensure compliance with waiver requirements and return to the satisfactory achievement of the waiver participant’s person-centered plan of care.
- All actions are logged in the DPHSS system, including date of discovery, corrective steps taken, and resolution date, and retained for CMS or other regulatory review.
- DPHSS will review problems and corrective actions initially on a monthly basis and then on a quarterly basis to identify and evaluate systemic issues and implement preventive policies and practices.
- DPHSS partners and stakeholders will receive briefings on systemic issues for collaborative mitigation, particularly in instances where the work of external entities (e.g., referring agencies) is implicated in the problem, corrective action, or preventive policy and practice.

**ii. Remediation Data Aggregation**

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<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 health and welfare that are currently non-operational.

- No
- Yes

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

## Appendix H: Quality Improvement Strategy (1 of 3)

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Under Section 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 (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, 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 QIS 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 QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## Appendix H: Quality Improvement Strategy (2 of 3)

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### 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.

DPHSS will utilize a continuous quality improvement approach to review and analyze waiver performance data. DPHSS will engage internal and external partners throughout the continuous quality improvement process to elicit expertise and insight into opportunities for program improvement.

The following is an overview of the process to trend, prioritize, and implement system improvements, including waiver design changes, resulting from an analysis of discovery and remediation information.

**Analysis**

1. Is there a problem (single instance or trend) indicated by the monitoring data? If yes, test data (Step 2). If no, return to monitoring.
2. Is the problem real (e.g., not a statistical artifact)? If yes, identify what type of problem is indicated (i.e., policy, process, and/or bad actor). If no, return to monitoring.
3. Do existing remediation processes address the identified problem? If yes, remediate and return to monitoring. If no, enter appropriate system improvement realm (i.e., policy or process analysis).

**System Improvement: Policy Analysis**

1. Can the problem's cause(s) be identified from analysis of the monitoring data? If yes, develop data-driven policy alternatives. If no, develop theory-driven policy alternatives.
2. Test policy alternative(s).
3. Select best policy alternative.
4. Enact new policy and return to monitoring.

**Process Analysis**

1. Is the problem an internal (DPHSS) or external process issue?
  - 2a. If it is an internal process issue, can the cause(s) be identified from analysis of the monitoring data? If yes, develop data-driven internal process alternatives. If no, develop theory-driven internal process alternatives.
  - 2b. If it is an external process issue, can the cause(s) be identified from analysis of the monitoring data? If yes, develop data-driven external process alternatives. If no, develop theory-driven external process alternatives.
3. Test process alternative(s).
4. Select best process alternative.
5. Enact new process(es) and return to monitoring.

**ii. 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 type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**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.

In accordance with the process outlined above in H-1-a, DPHSS, in partnership with internal and external stakeholders, will implement a systematic and standardized approach for reviewing key quality and performance data.

DPHSS will remain engaged with all stakeholders in its efforts to continuously monitor and improve the quality of program operations, participant satisfaction with services, and participant outcomes. The approach will be subject to continuous evaluation and refinement as DPHSS gains valuable insight throughout the implementation process. DPHSS will also leverage the CEDDERS Advisory Council (CAC), an advisory group comprised primarily of individuals with disabilities and their families. CEDDERS provides significant input and supports in the areas of education, transportation, health, quality assurance, assistive technology, early intervention, childcare, independent living, and employment to create pathways to address the unmet needs of individuals with disabilities and their families.

DPHSS will also engage the designated Long-Term Care Ombudsmen within BAPS. The Long-Term Care Ombudsmen serves to protect the health, safety, welfare, and right of older residents of long-term care settings by identifying, investigating, and resolving complaints made by or on behalf of residents of these settings. The assisted living residence will be added to the list of locations under the Long-Term Care Ombudsmen’s supervision which currently includes St. Dominic’s Senior Care Home, GMH Skilled Nursing Unit, and adult day program locations.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

During the first year of waiver implementation, DPHSS will conduct monthly meetings with internal and external stakeholders to review operations, quality, and performance monitoring data. The DPHSS operations team will assess the need for system operations or quality monitoring changes in consultation and coordination with system partners. The analysis and any resulting recommendations will be shared with program providers and include any related technical assistance or updated training guidance.

DPHSS anticipates that the frequency of review and consultation regarding the quality improvement strategy evaluation process will be reduced to quarterly in Years 2 and 3 of program operations.

**Appendix H: Quality Improvement Strategy (3 of 3)**

**H-2: Use of a Patient Experience of Care/Quality of Life Survey**

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

- No
- Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

- HCBS CAHPS Survey :
- NCI Survey :
- NCI AD Survey :
- Other (*Please provide a description of the survey tool used*):

**Appendix I: Financial Accountability**

**I-1: Financial Integrity and Accountability**

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit

program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DPHSS employs a variety of methods to help ensure the integrity of Medicaid payments. Similar methods will be applied to the review and approval of all payments made for waiver services and include the following: a) DPHSS currently performs independent reviews for 100% of Medicaid billing claims. All claims for payment are reviewed individually for form and content prior to being batched to the Department of Administration (DOA) for payment. In addition to the initial review of all claims prior to payment, DPHSS conducts a second line review by Quality Improvement Coordinator staff who is a certified coder; b) All claims are verified by trained and qualified claims processing and review officers (CPRO). Waiver claims for payment will be assigned to a designated CPRO(s). Once submitted, each claim undergoes a comprehensive review by Claims Review and Program Oversight (CRPO) staff. CRPO reviewers examine every claim to verify beneficiary eligibility, alignment with the approved person-centered service plan, accuracy of procedure codes and units, and completeness of supporting documentation. Claims for payment are reviewed daily, and a weekly quality review is performed by the Quality Improvement Coordinator prior to claims batching. Ernst and Young conducts the annual single audit of all Medicaid payments for DPHSS.; c) BHCFA, a bureau under DPW, is responsible for conducting financial audits of the waiver program. BHCFA operates under 10 GCA Chapter 2. Per rule, BHCFA has 45 days to review and resolve all claims. In addition, all claims for Medicaid payment must be submitted by providers within 365 from the date of service.

## **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 Assurance:**

**The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.**

##### **i. Sub-Assurances:**

**a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**

##### **Performance Measures**

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

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

##### **Performance Measure:**

**Clean claims submitted and processed for payment are resolved in accordance with program requirements and timelines. Numerator: Number of clean claims resolved in accordance with program requirements and timelines. Denominator: Total number claims submitted**

##### **Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> <b>Other</b> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> <i>Describe Group:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> <b>Other</b> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

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

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="text"/>	
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other</i> Specify: <input type="text"/>

**b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of waiver claims paid using the correct rates as specified in the waiver application. Numerator: Number of claims paid using the correct rate as specified in the waiver application Denominator: Total number of claims**

**Data Source (Select one):**

**Financial audits**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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

**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 and the state's method for analyzing

information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

All information relating to this assurance is collected through a review and analysis of claims data provided to BHCFA. Individual issues/concerns related to appropriate documentation of services billed identified during the review of individual records are addressed immediately by the CRPOs and resolved in coordination with the provider responsible for submitting the claim(s). Providers may be required to submit Corrective Action Plans addressing identified issues that must be reviewed and approved by BHCFA. Evidence collected via claims data is reviewed and analyzed throughout the year by BHCFA to identify any systemic issues or deficiencies. DPW and BHCFA will develop and deliver provider training or technical guidance on systemic issues or deficiencies, as needed.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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 Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix I: Financial Accountability**

**I-2: Rates, Billing and Claims (1 of 3)**

**a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

*Development of reimbursement rates for this initial waiver application occurred through a series of intensive stakeholder input and engagement sessions. Over several months, DPHSS collaborated with internal and external stakeholders to design an initial service array intended to meet the needs of the target population in home- and community-based settings. Throughout this process, DPHSS and stakeholders acknowledged that the proposed waiver service array substantially aligns with many existing, non-Medicaid funded HCBS program and services currently delivered through various programs on Guam.*

*However, because this represents Guam's first-ever Medicaid-funded HCBS program, stakeholders emphasized the unprecedented nature of establishing Medicaid-compliant rate structures on an island where long-standing HCBS models have historically relied on local appropriations, federal block grants, and other non-Medicaid funding streams. The transition to a formal Medicaid framework required additional attention to federal standards, documentation requirements, and cost-build methodologies not previously applied in Guam's HCBS environment. DPHSS established waiver reimbursement rates using a standardized cost-build methodology informed by Guam's existing HCBS and provider contracts, structured stakeholder engagement, and the 30-day public comment period beginning March 16, 2026.*

*For each service, DPHSS defined billable units and staffing models, then constructed rates using direct wages, fringe, productivity, supervision, operation, administration, , and travel factors. Estimated costs were calibrated to existing HCBS program operational costs to promote provider participation and labor market stability. Final rates will be mapped to specific codes and units and paid through the DPHSS claims system with pre- and post-payment oversight by CPRO/Quality Coordination staff, BHCFA financial audits, and DOA batching, review, and draw-down processes. DPHSS will apply documented annual trends, rebase rates at least once during the five-year cycle, and use ongoing monitoring (e.g., clean claims, timeliness, and correct rate usage) to ensure continued alignment with the rate determination methodology.*

*To help ensure reimbursement levels reflect both service delivery realities and Guam's unique operating environment, DPHSS analyzed existing contracts and cost structures while explicitly incorporating the island's higher cost of living, geographic isolation, limited provider supply, shipping costs, and wage competition across a small labor market. Guam's geographic isolation drives higher procurement costs for supplies, fuel, food, transportation, and other inputs essential to HCBS operations. Additionally, a constrained workforce—where providers often compete with federal agencies and military contractors—requires wage assumptions that differ substantially from mainland comparators. These factors were deliberately integrated into the rate-setting methodology to avoid underestimating the actual costs of delivering services on the island.*

*These reimbursement rate estimates were shared with stakeholders for iterative input and refinement. Stakeholders consistently reinforced the importance of designing rates that acknowledge Guam's economic realities, its comparatively small HCBS provider market, and the significant administrative and operational shifts required as the island launches Medicaid-funded HCBS for the first time . In addition to the broader engagement process, DPHSS solicited and evaluated public feedback during the 30-day public comment period beginning March 16, 2026, to further ensure transparency, accuracy, and local relevance of the proposed reimbursement structure.*

- 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:*

*DPHSS operates a fully State-run, fee-for-service Medicaid claims payment system through which all waiver billings flow directly from enrolled providers. The Department does not rely on a fiscal intermediary or third-party administrator; instead, all claims are processed within DPHSS to maintain transparent oversight and strong financial controls. Providers receive training and technical assistance during onboarding to ensure they understand service definitions, billing rules, and documentation expectations before submitting any claims.*

*All waiver claims are entered into the DPHSS billing portal, which functions as the official system of record for tracking, adjudication, and payment. Once submitted, each claim undergoes a comprehensive review by Claims Review and Program Oversight (CRPO) staff. CRPO reviewers examine every claim to verify beneficiary eligibility, alignment with the approved person-centered service plan, accuracy of procedure codes and units, and completeness of supporting documentation. This review also identifies inconsistencies, potential errors, or indications of fraud, waste, or abuse. Claims that are incomplete or do not meet Medicaid requirements are suspended and returned to providers for correction, while claims requiring further scrutiny are escalated for additional review.*

*Only claims that meet all accuracy, completeness, and compliance requirements proceed to fiscal approval. Approved claims are then routed to the Department of Administration for batching, reconciliation, and payment in accordance with territorial fiscal procedures. This direct, end-to-end review process ensures rigorous internal control over federal and territorial funds and allows DPHSS to detect issues early, reduce improper payments, and uphold CMS financial accountability expectations.*

*Recognizing Guam's small HCBS provider market and varying levels of administrative capacity, CRPO staff also provide ongoing technical support to assist providers in navigating billing requirements, resolving claim issues, and maintaining compliance. Through these integrated processes, DPHSS sustains a claims management structure that supports payment accuracy, program integrity, and timely reimbursement for Guam's Medicaid-funded HCBS waiver providers.*

**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:

*The Bureau of Budget Management Resources (BBMR) is the agency responsible for verifying all funds loaded into the claims payment system, including federal and local match dollars. The Department of Administration (DOA) is responsible for reviewing all batched claims submitted by BHCFA and verifying the availability of federal and local funding. DOA also has access to the federal system to draw down federal dollars, as well as determine the extent of available local and federal dollars.*

*CPROs employed by the BHCFA review 100% of all Medicaid claims, including claims for payment for delivery of waiver program services. This review includes analysis of supporting documentation, service descriptions, and provider qualifications. All claims reviewed must include supporting documentation at the time of billing.*

*a) Waiver program participants will be pre-authorized to receive waiver services for a period of six months during the first year of waiver enrollment. In subsequent years, waiver program participants may receive pre-authorization for waiver services for a period of one year to coincide with the eligibility redetermination timeline.*

*b) As part of the pre-authorization process, all person-centered plans of care will be submitted to BHCFA for review and approval. BHCFA will retain these documents to facilitate review of each waiver service claim and ensure that the service(s) submitted for billing was included in the individual's person-centered plan of care.*

*c) CRPOs will review all claims for waiver services against the approved person-centered plan of care and pre-authorization to ensure that services were provided as authorized.*

**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:*

*The Bureau of Budget Management Resources (BBMR) is the agency responsible for verifying all funds loaded into the claims payment system, including federal and local match dollars. The Department of Administration (DOA) is responsible for reviewing all batched claims submitted by BHCFA and verifying the availability of feral and local funding. DOA also has access to the federal system to draw down federal dollars, as well as determine the extent of available local and federal dollars.*

*CPROs employed by the BHCFA review 100% of all Medicaid claims, including claims for payment for delivery of waiver program services. This review includes analysis of supporting documentation, service descriptions, and provider qualifications. All claims reviewed must include supporting documentation at the time of billing.*

*a) Waiver program participants will be pre-authorized to receive waiver services for a period of six months during the first year of waiver enrollment. In subsequent years, waiver program participants may receive pre-authorization for waiver services for a period of one year to coincide with the eligibility redetermination timeline.*

*b) As part of the pre-authorization process, all person-centered plans of care will be submitted to BHCFA for review and approval. BHCFA will retain these documents to facilitate review of each waiver service claim and ensure that the service(s) submitted for billing was included in the individual’s person-centered plan of care.*

*c) CRPOs will review all claims for waiver services against the approved person-centered plan of care and pre-authorization to ensure that services were provided as authorized.*

*d) The Bureau of Budget Management Resources (BBMR) is the agency responsible for verifying all funds loaded into the claims payment system, including federal and local match dollars. The Department of Administration (DOA) is responsible for reviewing all batched claims submitted by BHCFA and verifying the availability of feral and local funding. DOA also has access to the federal system to draw down federal dollars, as well as determine the extent of available local and federal dollars.*

● ***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:*

*Guam government provider agencies and/or their vendors may receive payment for the delivery of waiver services and include the following: Behavioral Health and Wellness Clinic (GBHWC, Division of Senior Citizens (GSC)), Department of Integrated Services for Individuals with Disabilities (DISID), and Division of Homeless Assistance and Poverty Prevention. The waiver services these local government agencies may provide include case management, respite, specialized therapies, therapeutic support services, arts therapies and transition assistance.*

**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:*

- *The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.*
- *The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.*
- *The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.*

*Describe the recoupment process:*

**Appendix I: Financial Accountability**

**I-3: Payment (6 of 7)**

**f. Provider Retention of Payments.** *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- *Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.*
- *Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.*

*Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.*

*Appendix I: Financial Accountability**I-3: Payment (7 of 7)***g. Additional Payment Arrangements****i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:**

- **No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).**

*Specify the governmental agency (or agencies) to which reassignment may be made.*

**ii. Organized Health Care Delivery System. Select one:**

- **No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.**
- **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.**

*Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:*

**iii. Contracts with MCOs, PIHPs or PAHPs.**

- **The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- **The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 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 section 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 section 1915(b)/section 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 section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.*
- *This waiver is a part of a concurrent section 1115/section 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 section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.*
- *If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.*

*In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.*

**Appendix I: Financial Accountability**

**I-4: Non-Federal Matching Funds (1 of 3)**

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid Agency*
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.*

*If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

- Other State Level Source(s) of Funds.**

*Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

- a) Local and federal match funds support the operation of this waiver program.
- b) The Bureau of Budget Management Resources (BBMR) is the agency responsible for verifying all funds loaded into the claims payment system, including federal and local match dollars. The Department of Administration (DOA) is responsible for reviewing all batched claims submitted by BHCFA and verifying the availability of feral and local funding.
- c) DOA accesses the federal system to draw down federal dollars, as well as determine the extent of available local and federal dollars. DOA directly expends the funds 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***

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### ***I-5: Exclusion of Medicaid Payment for Room and Board***

***a. Services Furnished in Residential Settings. Select one:***

- No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

***b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:***

*The program will not include costs of room and board (R&B) residential support service reimbursement rate. Only service (care) costs are reimbursed by Medicaid; housing, food, and utilities are categorically excluded in accordance with federal policy and CMS instructions for §1915(c) waivers.*

*Rate-setting methodology that excludes room & board*

*Cost identification and removal: Guam has completed a cost analysis of existing residential HCBS providers to separate care-related costs (e.g., staffing, supervision, habilitation, clinical oversight) from housing-related costs (e.g., rent/mortgage, utilities, meals, routine room maintenance). Only the care-related cost components were used to establish HCBS payment rates; all housing-related cost elements are excluded from the rate build methodology.*

*Documentation: DPHSS will require residential service providers to complete cost survey tools, and attestation forms requiring categorical reporting that distinguishes R&B from care costs to ensure financial accountability per §441.303 and CMS waiver instructions.*

*How room & board will be paid (outside Medicaid)*

*To ensure affordability while maintaining the federal prohibition on Medicaid funding of R&B, Guam will rely on non-Medicaid housing resources for individuals in §1915(c) residential settings, including but not limited to: HUD Section 8 Housing Choice Vouchers (HCV) and other locally funded housing program vouchers will be leveraged to subsidize rent for eligible individuals. (Medicaid excludes R&B; vouchers provide the separate housing funding stream.)*

*Other federal/territorial housing subsidies (e.g., local vouchers, project-based assistance, or comparable rent subsidy programs administered by territorial housing authorities and programs to cover the housing portion of costs in compliant settings.*

*Note: This approach preserves the Medicaid R&B exclusion while operationalizing a distinct funding pathway for housing, consistent with CMS training guidance that states must describe their method for excluding R&B and preventing unallowable costs.*

*Oversight and compliance*

*Provider agreements & audits: Provider enrollment agreements will explicitly prohibit using Medicaid funds for R&B and require supporting documentation for cost allocations; DPHSS will conduct periodic desk reviews and targeted audits to verify compliance.*

*Care setting standards: Person-centered plans will note the setting choice and the non-Medicaid source(s) covering R&B, consistent with the HCBS settings rule requirement that residential service descriptions reflect resources available for room and board.*

## ***Appendix I: Financial Accountability***

### ***I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver***

***Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:***

- No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

**Appendix I: Financial Accountability**

**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)**

a. **Co-Payment Requirements.** Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

- No. The state does not impose a co-payment or similar charge upon participants for waiver services.
- Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible
- Coinsurance
- Co-Payment
- Other charge

Specify:

**Appendix I: Financial Accountability**

**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

a. **Co-Payment Requirements.**

ii. **Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

**Appendix I: Financial Accountability**

**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**

a. **Co-Payment Requirements.**

iii. **Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

**Appendix I: Financial Accountability**

*I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)*

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

*Answers provided in Appendix I-7-a indicate that you do not need to complete this section.*

**Appendix I: Financial Accountability**

*I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)*

**b. Other State Requirement for Cost Sharing.** Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

- No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

**Appendix J: Cost Neutrality Demonstration**

*J-1: Composite Overview and Demonstration of Cost-Neutrality Formula*

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: Hospital, Nursing Facility**

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1		14648.34	14648.34	623237.50	20556.60	643794.10	629145.76
2		14648.34	14648.34	623237.50	20556.60	643794.10	629145.76
3		14648.34	14648.34	623237.50	20556.60	643794.10	629145.76

**Appendix J: Cost Neutrality Demonstration**

*J-2: Derivation of Estimates (1 of 7)*

**a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Hospital	Nursing Facility
Year 1	35	15	15
Year 2	45	20	20
Year 3	55	25	25

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (2 of 7)**

**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.

Because this is a new waiver, the average length-of-stay (LOS) estimate is necessarily based on planning assumptions rather than historical waiver experience. For purposes of the initial cost-neutrality demonstration, DPHSS assumes participants will remain continuously enrolled for a full waiver year (365 days). This assumption reflects the clinical and functional needs of the target population, many of whom have experienced—or are at risk of—extended hospital and/or nursing facility stays and are expected to require ongoing home- and community-based services to maintain health and safety in the community. While DPHSS anticipates many participants may initially receive services in an assisted living residential setting, the service setting may change over time (e.g., a transition to a private residence or family home) without necessarily ending waiver enrollment. DPHSS will monitor LOS and transitions across settings through enrollment and service utilization data and will refine this estimate in future waiver submissions or amendments as operational data become available.

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (3 of 7)**

**c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

**i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Factor D was estimated based on non-Medicaid funded HCBS program costs for a sample of individuals who have characteristics similar to the waiver target population. These non-Medicaid funded HCBS programs include residential settings and other services and supports similar to those offered under the 1915(c) waiver. Total costs were aggregated across individual program participants to develop an average cost of similar non-Medicaid funded HCBS.

**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 estimated based on actual cost and claims data for individuals residing in numerous group residential settings who have characteristics similar to the waiver target population. Total costs were aggregated across the individuals sampled to develop an average estimated cost for all other Medicaid services not provided in the group residential settings.

**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:

Factor G was estimated based on actual cost and claims data from long-term stay patients at Guam Memorial Hospital (GMH) identified by DPHSS and stakeholders as members of the proposed waiver target population. Total costs were aggregated across individual patients to develop an average cost of care in GMH services, including cost report data for both acute care bed days and nursing facility bed days.

**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 estimated based on actual cost and claims data from long-term stay patients at Guam Memorial Hospital identified by DPHSS and stakeholders as members of the proposed waiver target population. Total costs were aggregated across individual patients to develop an average cost for all other Medicaid services not provided in an in-patient setting.

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (4 of 7)**

**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.

<b>Waiver Services</b>	
Nursing	
Occupational Therapy	
Physical Therapy	
Speech and Language Therapy	
Adaptive Aids	
Adult Day Services	
Arts Therapy	
Case Management	
Home Delivered Meals	
Home Modifications	
Home-Based Support Services	
Residential Support Services	
Respite	
Therapeutic Support Services	
Transition Assistance	
Vehicle Modifications	

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (5 of 7)**

**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
<b>Nursing Total:</b>						528422.40
Nursing Services- RN	15 minute	30	384.00	19.55	225216.00	
Nursing Services- LPN	15 minute	30	768.00	13.16	303206.40	
<b>Occupational Therapy Total:</b>						145184.00
Occupational Therapy	15 minute	10	416.00	34.90	145184.00	
<b>Physical Therapy Total:</b>						145184.00
Physical Therapy	15 minute	10	416.00	34.90	145184.00	
<b>Speech and Language Therapy Total:</b>						145184.00
Speech and Language Therapy	15 minute	10	416.00	34.90	145184.00	
<b>Adaptive Aids Total:</b>						75000.00
Adaptive Aids- Medical Equipment	1	20	1.00	1875.00	37500.00	
Adaptive Aids- NOS	15 minute	20	1.00	1875.00	37500.00	
<b>Adult Day Services Total:</b>						73008.00
Adult Day Services	1	5	130.00	112.32	73008.00	
<b>Arts Therapy Total:</b>						112608.00
Arts Therapy	15 minute	15	384.00	19.55	112608.00	
<b>Case Management Total:</b>						168480.00
Case Management	1	30	12.00	468.00	168480.00	
<b>Home Delivered Meals Total:</b>						55516.50
Home Delivered Meals	1	5	730.00	15.21	55516.50	
<b>Home Modifications Total:</b>						90000.00
Home Modifications	1	5	1.00	18000.00	90000.00	
<b>Home-Based Support Services Total:</b>						341640.00
Home-Based Support Services	1	5	365.00	187.20	341640.00	
<b>Residential Support Services Total:</b>						3159000.00
<p><b>GRAND TOTAL:</b>                      Total Estimated Unduplicated Participants: 35                      Factor D (Divide total by number of participants):                      Average Length of Stay on the Waiver: 365</p>						

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Support Services	1	25	12.00	10530.00	3159000.00	
<b>Respite Total:</b>						77875.20
Respite	15 minute	5	3328.00	4.68	77875.20	
<b>Therapeutic Support Services Total:</b>						164236.80
Therapeutic Support Services	15 minute	20	624.00	13.16	164236.80	
<b>Transition Assistance Total:</b>						112500.00
Transition Assistance	1	30	1.00	3750.00	112500.00	
<b>Vehicle Modifications Total:</b>						811250.00
Vehicle Modifications	1	5	11.00	14750.00	811250.00	
<b>GRAND TOTAL:</b> Total Estimated Unduplicated Participants: 35 Factor D (Divide total by number of participants): Average Length of Stay on the Waiver: 365						

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (6 of 7)**

**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
<b>Nursing Total:</b>						704563.20
Nursing Services-RN	15 minute	40	384.00	19.55	300288.00	
Nursing Services-LPN	15 minute	40	768.00	13.16	404275.20	
<b>Occupational Therapy Total:</b>						174220.80
<b>GRAND TOTAL:</b> Total Estimated Unduplicated Participants: 45 Factor D (Divide total by number of participants): Average Length of Stay on the Waiver: 365						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Occupational Therapy	15 minute	12	416.00	34.90	174220.80	
<b>Physical Therapy Total:</b>						290368.00
Physical Therapy	15 minute	20	416.00	34.90	290368.00	
<b>Speech and Language Therapy Total:</b>						174220.80
Speech and Language Therapy	15 minute	12	416.00	34.90	174220.80	
<b>Adaptive Aids Total:</b>						150000.00
Adaptive Aids- Medical Equipment	1	40	1.00	1875.00	75000.00	
Adaptive Aids- NOS	1	40	1.00	1875.00	75000.00	
<b>Adult Day Services Total:</b>						146016.00
Adult Day Services	1	10	130.00	112.32	146016.00	
<b>Arts Therapy Total:</b>						150144.00
Arts Therapy	15 minute	20	384.00	19.55	150144.00	
<b>Case Management Total:</b>						224640.00
Case Management	1	40	12.00	468.00	224640.00	
<b>Home Delivered Meals Total:</b>						111033.00
Home Delivered Meals	1	10	730.00	15.21	111033.00	
<b>Home Modifications Total:</b>						90000.00
Home Modifications	1	5	1.00	18000.00	90000.00	
<b>Home-Based Support Services Total:</b>						683280.00
Home-Based Support Services	1	10	365.00	187.20	683280.00	
<b>Residential Support Services Total:</b>						3790800.00
Residential Support Services	1	30	12.00	10530.00	3790800.00	
<b>Respite Total:</b>						155750.40
Respite	15 minute	10	3328.00	4.68	155750.40	
<b>GRAND TOTAL:</b> Total Estimated Unduplicated Participants: 45 Factor D (Divide total by number of participants): Average Length of Stay on the Waiver: 365						

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Therapeutic Support Services Total:</b>						246355.20
Therapeutic Support Services	15 minute	30	624.00	13.16	246355.20	
<b>Transition Assistance Total:</b>						18750.00
Transition Assistance	1	5	1.00	3750.00	18750.00	
<b>Vehicle Modifications Total:</b>						73750.00
Vehicle Modifications	1	5	1.00	14750.00	73750.00	
<b>GRAND TOTAL:</b> Total Estimated Unduplicated Participants: 45 Factor D (Divide total by number of participants): Average Length of Stay on the Waiver: 365						

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (7 of 7)**

**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
<b>Nursing Total:</b>						880704.00
Nursing Services-RN	15 minute	50	384.00	19.55	375360.00	
Nursing Services-LPN	15 minute	50	768.00	13.16	505344.00	
<b>Occupational Therapy Total:</b>						217776.00
Occupational Therapy	15 minute	15	416.00	34.90	217776.00	
<b>Physical Therapy Total:</b>						290368.00
Physical Therapy	15 minute	20	416.00	34.90	290368.00	
<b>Speech and Language Therapy Total:</b>						217776.00
<b>GRAND TOTAL:</b> Total Estimated Unduplicated Participants: 55 Factor D (Divide total by number of participants): Average Length of Stay on the Waiver: 365						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech and Language Therapy	15 minute	15	416.00	34.90	217776.00	
<b>Adaptive Aids Total:</b>						150000.00
Adaptive Aids- Medical Equipment	1	40	1.00	1875.00	75000.00	
Adaptive Aids- NOS	1	40	1.00	1875.00	75000.00	
<b>Adult Day Services Total:</b>						219024.00
Adult Day Services	1	15	130.00	112.32	219024.00	
<b>Arts Therapy Total:</b>						150144.00
Arts Therapy	15 minute	20	384.00	19.55	150144.00	
<b>Case Management Total:</b>						280800.00
Case Management	1	50	12.00	468.00	280800.00	
<b>Home Delivered Meals Total:</b>						166549.50
Home Delivered Meals	1	15	730.00	15.21	166549.50	
<b>Home Modifications Total:</b>						90000.00
Home Modifications	1	5	1.00	18000.00	90000.00	
<b>Home-Based Support Services Total:</b>						341640.00
Home-Based Support Services	1	5	365.00	187.20	341640.00	
<b>Residential Support Services Total:</b>						4422600.00
Residential Support Services	1	35	12.00	10530.00	4422600.00	
<b>Respite Total:</b>						233625.60
Respite	15 minute	15	3328.00	4.68	233625.60	
<b>Therapeutic Support Services Total:</b>						246355.20
Therapeutic Support Services	15 minute	30	624.00	13.16	246355.20	
<b>Transition Assistance Total:</b>						37500.00
<p><b>GRAND TOTAL:</b>                      Total Estimated Unduplicated Participants: 55                      Factor D (Divide total by number of participants):                      Average Length of Stay on the Waiver: 365</p>						

<i>Waiver Service/ Component</i>	<i>Unit</i>	<i># Users</i>	<i>Avg. Units Per User</i>	<i>Avg. Cost/ Unit</i>	<i>Component Cost</i>	<i>Total Cost</i>
<i>Transition Assistance</i>	1	10	1.00	3750.00	37500.00	
<b><i>Vehicle Modifications Total:</i></b>						73750.00
<i>Vehicle Modifications</i>	1	5	1.00	14750.00	73750.00	
<p><b>GRAND TOTAL:</b>                      Total Estimated Unduplicated Participants: 55                      Factor D (Divide total by number of participants):                      Average Length of Stay on the Waiver: 365</p>						