

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
	Specify: <div style="border: 1px solid black; height: 20px; width: 100%; text-align: right;">↕</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.

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**Appendix H: Quality Improvement Strategy (1 of 2)**

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

**Quality Improvement Strategy: Minimum Components**

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

In the 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;
- 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 OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the 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 2)**

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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.

OCDD has a multi-tiered system for trending, prioritizing, and implementing system improvements. Each level (Direct Service Provider Agency, Support Coordination Agency, LGE, OCDD State Office, and BHSF) within the system is required to design and implement a Quality Management Strategy.

Meet with Office of Aging and Adult Services (OAAS), the office within LDH that operates the waiver programs for adult onset disabilities, as needed to discuss cross waiver issues.

Direct Service Provider and Support Coordination Agency Processes:

- Direct service provider and support coordination agencies are required to have a Quality Management Strategy that includes collecting information and data to learn about the quality of services, analyzing and reviewing data to identify trends and patterns, prioritizing improvement goals, implementing the strategies and actions on their quality enhancement plan, and evaluating the effectiveness of the strategies. At a minimum, agencies must review: 1) critical incident data, 2) complaint data, 3) data from case record reviews, and 4) interview/survey data from participants and families. The review process must include review by internal review team(s) composed of agency programmatic and management staff and an external review by the board of directors with stakeholder representation or a separate committee that includes stakeholders. Annually, agencies must submit to OCDD documentation to verify that they engage in ongoing, continuous quality review and enhancement activities.

LGE Processes:

- LGE is also required to have a Quality Management Strategy. They are required to collect information on performance indicators, conduct remediation as needed, aggregate data and review to identify trends and patterns and areas in which improvement is needed, and prioritize needed improvements. They are required to design and implement quality enhancement strategies and evaluate the effectiveness of those strategies. Each LGE has a Quality Specialist whose function is to facilitate data analysis and review and a Regional Office Specialist whose function is to provide training and technical assistance to support coordination and direct service provider agencies. Within each LGE, data review will be conducted by programmatic and management staff and by the Regional Advisory Committee which is composed of stakeholders. OCDD State Office staff visit each region, LGE annually to validate the quarterly data reported to OCDD State Office on performance indicators, to assure that remediation and system improvements occur as needed, and to provide technical assistance.

OCDD State Office Processes:

- Aggregate data for waiver performance indicators are reviewed for trends and patterns on a quarterly basis by the OCDD Performance Review Committee. The OCDD Performance Review Committee is composed of executive management and programmatic staff. The committee's role is to identify areas for which improvements are needed and to recommend strategies to address the identified areas. These recommendations are presented to the OCDD Assistant Secretary for consideration and approval. The recommendations, performance indicator data reports, and quality improvement initiatives status reports are submitted to the Bureau of Health Services Financing (BHSF) on a quarterly basis.

- Remediation for individual cases (e.g., from individual critical incidents reports, complaints reports, supervisory case record reviews, etc.) is identified by LGE staff and OCDD State Office Programmatic staff. Remediation reports are reviewed by the OCDD Performance Review Committee to identify trends and patterns and to assure timely corrective action.

- LGE performance indicators are integrated into the entire QMS for the waiver. The paid service provider and support coordination agency strategies are not integrated into the entire QMS or the waiver because they serve multiple waiver and Medicaid targeted populations.

The Quality Improvement System (QIS) for the waiver is part of a cross-waiver function of the Office for Citizens with Developmental Disabilities (OCDD) and Office of Aging and Adult Services (OAAS). The purpose of the QIS is to assess and promote the quality of waiver programs serving older persons and adults with physical, intellectual and developmental disabilities. In addition to the Children's Choice waiver, these waivers include:

- Adult Day Health Care Waiver

- New Opportunities Waiver

- Residential Options Waiver

- Supports Waiver

- Community Choices Waiver

Several cross agency work groups comprise the cross waiver Quality Improvement System. The mission, composition and major tasks of each entity represented under the QIS are described below.

Cross-Waiver Stakeholder Advisory Committee meets twice a year. Members include Medicaid Program Support and Waivers (MPSW), Adult Protective Services (APS), state operating agencies (Office for Citizens with Developmental Disabilities and Office of Aging Supports and Services) agencies, consumers, providers, and advocates. The mission of the group is to:

- Assure that decisions with respect to HCBS waivers are informed by the diversity of perspectives and experiences of HCBS participants and other stakeholders.
- Identify or update measures for assessing HCBS waiver quality
- Evaluate performance data against adopted measures
- Advise on quality improvement initiatives
- Help integrate quality initiatives with other public/private efforts
- Review and comment on public performance reports
- Communicate results of QIS activities stratified by waiver, to agencies, waiver providers, participants, families and other interested parties, and the public annually

Cross-Waiver Executive Management Team meets quarterly. Members include Assistant Secretaries & Section Chiefs/Division Directors of OAAS, OCDD, MPSW and HSS. The mission of the group is to:

- Oversee the performance of HCBS waivers to assure their effectiveness, efficiency and integration.
- Adopt quality standards and measures for HCBS waivers.
- Evaluate performance reports on a scheduled basis.
- Take action on recommendations from Advisory Group Cross Waiver Quality Team/Workgroups.
- Establish priorities and allocate resources
- Establish workgroups to design, coordinate and integrate improvement strategies.
- Trouble shoot critical issues

Cross-Waiver Quality Review Team meets every other month. The team is composed of quality, programmatic and IT information technology representatives from the Program Offices, Medicaid and DHH IT. The Cross-Waiver Quality Review Team reports to the Cross-Waiver Executive Management

Team. The mission of this group is to:

- Integrate and align HCBS waiver policies, practices and tools to assure maximum effectiveness and efficiency. Review draft policies, CMS applications/renewals, contracts/agreements and reports related to HCBS waivers to assure consistency with quality standards.
- Identify opportunities for coordinating, integrating and consolidating waiver activities and functions.
- Share information and knowledge regarding best and promising practices.
- Design, generate and review comparative performance reports.
- Standing agenda items for this team include continuous collaboration on joint policy whenever possible for rules, issues, and policies for Support Coordination, Direct Service Providers and Critical Incident Reporting

**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 checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

**b. System Design Changes**

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

OCDD Process:

- Following system design changes, data on performance indicators are reviewed by the OCDD Performance Review Committee to assure that the information is useful and accurate and to determine if performance has improved. Input is sought, as appropriate, from support coordination and direct service provider agencies, participants and their families, and other stakeholders, to determine whether the system design change is helping to improve efficiency and effectiveness of waiver supports and services.

BHSF Processes:

- Following system design changes, data will be monitored to determine if the system redesign was effective in alleviating the problems it was created to correct. Performance measures will be modified as required. As data is gathered it will be reviewed and assessed by MPSW and the Quality Waiver Review Team. After each quarter of implementation, up to one year post-implementation, MPSW and the Team will assess the effectiveness of the redesign and present findings and recommendations to the Medicaid Director and the operating agency regarding the continued employ of the redesign in order to ensure effective outcomes.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

OCDD Process:

- Evaluation of the Quality Improvement Strategy occurs on an ongoing basis as data from discovery methods are entered into databases and reports of aggregate data are analyzed for trends and patterns. Questions are considered such as: Is the data useful? Is the frequency of data analyses

appropriate? Are the right persons involved in the review of data reports? Reports of Quality Improvement activities are communicated to agencies such as the DD Council and State Advisory Committee.

#### BHSF Processes:

- Based on the review of the quarterly reports from OCDD regarding recommendations, performance indicator data reports, and quality improvement initiatives status reports, summary reports regarding provider agency and regional office quality management strategy implementation, and other data that will be examined monthly to assess the status of the waiver assurances, along with quarterly examination of redesign, BHSF will be able to evaluate the effectiveness of the QIS on a continuing basis in preparation for the annual report due the Medicaid Director.
- A more formal review will occur on an annual basis by BHSF in collaboration with OCDD. The BHSF and OCDD will evaluate components of the quality improvement strategy including performance indicators, discovery methods, remediation strategies, databases, data aggregation and review processes etc. to determine if revisions are appropriate.

## Appendix I: Financial Accountability

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### 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).

LDH has a contract with the Fiscal Intermediary (FI) to perform Surveillance and Utilization Review (SURS) functions which includes investigation of fraud, waste and abuse; recovering of overpayments; and a minimum of 900 case reviews per calendar year. Additionally, LDH has a Program Integrity unit that performs reviews/investigations. The Program Integrity Unit performs 3 primary functions: SURS, Provider Enrollment and PERM (Payment Error Rate Measurement). Program Integrity's SURS Unit is responsible for conducting post-payment reviews of all fee-for-service Medicaid providers, including Children's Choice providers. Audits are conducted based on complaints from all sources. SURS also conducts data mining activities of all provider types in order to detect suspicious billing activities. Based on the complaints made and data mining conducted, individual cases are opened and investigated or Self-Audit notices are sent out to providers. Post-payment reviews in the Program Integrity function is based upon evidence revealed as a result of production runs, data mining runs, projects, complaints, referrals, and other SUR function activities. Random audits are also performed.

All complaint cases relating to fraud, waste and abuse of waiver providers are opened and investigated. Depending on the issues, referrals to protective agencies, program offices, the Medicaid Fraud Control Unit (MFCU), other law enforcement agencies, eligibility, etc. are made if warranted. Once a given provider is chosen for audit, the case is referred to professional staff (which may include RN, Dentists, medical doctors, etc.,) for review. A claims history and scientific sample are generated, producing a list of participants for detailed review. Medical records as well as other pertinent records are obtained from the given provider. Records are obtained from providers via mail or unannounced on-site visits. The SUR staff will thoroughly review the records for billing anomalies, policy compliance, and proper documentation. When overpayments are detected, monies are recovered by withholding or recoupment. When and if fraud or other serious infractions are detected, Program Integrity can impose serious sanctions, including fines, exclusion from Louisiana Medicaid, and referral to Louisiana's Attorney General for possible criminal prosecution. Project cases (which are focused reviews) involve waiver providers as well as other provider types

Financial audit of waivers is conducted by the Louisiana Legislative Auditor on a yearly basis to ensure the integrity of provider billings for Medicaid payment of waiver services. Additionally, the Louisiana Medicaid fiscal intermediary maintains a computerized claims processing system, with an extensive system of edits and audits.

All support coordination agencies are required to provide a yearly external audit including any subcontractors, based on allowable costs, in accordance with General Accounting Practices.

**Appendix I: Financial Accountability**

**Quality Improvement: Financial Accountability**

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

**a. Methods for Discovery: Financial Accountability**

*State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

**i. 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 in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

**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:**

**I.a.1. Number and percentage of services that were prior authorized correctly, according to policy, by the contractor. Numerator = Number of services that were prior authorized correctly; Denominator= total number of services reviewed in the sample.**

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**Medicaid Data Contractor**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = Confidence Interval = 95% +-5%
<input checked="" type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: Medicaid data contractor		Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**I.a.2. Number and percentage of waiver claims paid which did not exceed the approved rate. Numerator = Number of submitted waiver claims paid which did not exceed the approved rate; Denominator = Total number of paid claims**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**MMIS**

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

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

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.

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.

I.a.1: On an individual's plan of care, all waiver services codes are listed. Only those waiver services codes listed are prior authorized. Those services which have a hard cap are prior authorized with a hard cap. Services with a soft cap require OCDD and/or LGE override. The Medicaid data contractor's system does not allow the provider to bill for more than the service which is prior authorized. However, if services are prior authorized and are billed by the provider for the cap and later reduced, the provider could receive payment for more services than are PA'd.

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

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

I.a.1 and I.a.2: BHSF/MPSW will require OCDD to mandate that the provider void claims within specified period of time. Failure to do so by provider may result in further action such as referral to Program Integrity, withholding future payments until correction made, and training as necessary. In the event that problem appears to be systemic in nature, MSPW will require corrective action by OCDD including training of providers.

ii. **Remediation Data Aggregation**

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

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

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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

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### 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).

Rates for the payment of services are determined by the Office of Citizens with Developmental Disabilities (OCDD) upon approval by Medicaid. OCDD sets these rates with input from a group of interested parties, including but not limited to providers and or provider groups, program participants, advocates, and Medicaid representatives. Proposed service rates are promulgated through the Medicaid rulemaking process which includes opportunity for public input and comment. Final approval of proposed rates and oversight of the rate determination process is done by the Medicaid Director or his designee.

Rates for each service are based on following:

Family Support and Respite (Center Based) rates were negotiated based upon the estimated provider cost of rendering the service. This estimated cost is then put into cost projection model that estimates the potential of the service using historical and projected utilization trends. The cost of this service is then adjusted based on the availability of state funding or LDH's ability to secure appropriation.

When the Family Support services are self-directed, the method of rate determination differs from when the service is provider managed. The provider-managed rate includes a cost component in addition to the rate paid for the services delivered. This additional cost component serves as an "administrative fee" which is payable to the Personal Care Attendant provider managed services and the Fiscal Employer Agent for self-directed services, for exercising oversight and monitoring. The CC Waiver participant determines the rate, within the approved parameters to be paid to his self-directed support worker. The State requires the Fiscal Employer Agent to cover payroll taxes for the participant's direct support workers. This means that we require the Fiscal Employer Agent to ensure that payroll taxes are paid with the money paid to them through the Medicaid claims payment system and that they do not pass the total payment through to the worker without withholding taxes. In non-self-directed services this is done by the provider agency, but with self-direction the Fiscal Employer Agent must do this for the worker and fiscal/employer. All payments for self-direction are processed through the Medicaid claims payment system and are subject to all edits and maximum rate parameters in the system as established by Medicaid.

Support coordination service rates are based upon the providers cost of rendering the service and then adjusted based on the availability of state funding or DHH's ability to secure appropriation.

Environmental Accessibility Adaptations, Specialized Medical Equipment, Aquatic Therapy, Art Therapy, Hippotherapy/Therapeutic Horseback Riding, Music Therapy, Sensory Integration and Family Training are paid at the cost of the provision of the service within the annual waiver cap, according to a reasonable cost of this service based on comparable services provided in southern geographical areas and where services are provided through a CMS approved waiver in other states.

Both Housing Stabilization and Housing Stabilization Transition Service rates are based on the rate paid to support coordination agencies which employ individuals who have obtained a bachelor's degree and are qualified to provide two levels of supervision. An agency trainer or nurse consultant who meets the requirements as a support coordinator can also be reimbursed a per quarter hour rate for services provided. Administrative support, travel and office operating expenses are included in the 15 minute billing rate.

The state has several data sources that are used to indicate historical utilization. The first is a variant report of the CMS 372 that gives each of the data elements of the services listed on the 372 broken down by procedure code, services used, payments, and average cost per service. LDH also uses data on service utilization from the MARS Data Warehouse which is a 5 year claims extract repository. Data is pulled using SAS and analyzed for utilization trending. Cost projection models are then produced using this trend information.

All proposed rates are then plugged into a cost projection and model to produce an estimated total program cost and average cost per recipient which is then used to determine the effects of these rates on program cost effectiveness. Rates are then renegotiated or changed as needed.

Payment rates are available to participants through provider agencies, support coordination agencies, as well as through publication in the Louisiana Register. Participants may also receive information on service rates by contacting the LGE office.

- 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:

Billings for waiver services provided to participants in the waiver program are submitted first to the data contractor for post authorization. After services are authorized, providers bill directly to the Medicaid fiscal intermediary for payment.

Self-direction time sheets are submitted to the fiscal agent for processing. After time sheets are reviewed, all-time records are submitted to the data contractor for post authorization of services. After prior authorizations are released, the fiscal agent will bill the Medicaid fiscal intermediary for payment of all prior authorized and approved services. Payments for services rendered will be submitted to the fiscal agent.

## 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:

OCDD will use a prior authorization and post authorization system to insure that services provided and paid for are in accordance with the Plan of Care (POC).

Medicaid eligibility for services is checked and reviewed by the prior authorization entity. The Children's Choice (CC) waiver uses a system of prior and post authorization to ensure that services provided to waiver participants are provided in the scope, duration, and frequency as outlined in the participants plan of care. Services are prior authorized by the POC in quarterly increments and post authorized for payment after services have been rendered. DHH currently uses a contracted entity for its prior and post-authorizations.

All Medicaid waiver services are paid through prior authorization. Before any payments are made for Medicaid services, the participant is checked for eligibility for waiver services by the state fiscal intermediary. If the date of service matches Medicaid and waiver eligibility, then the claim is paid. If not, the claim is denied and a denial code of service ineligibility is given for the claim.

1. POC prescribed services are entered in the prior authorization system quarterly.
2. Upon the provision of services to the CC waiver participant, the provider submits data on the services provided to our post authorization entity which checks the service record against the POC listed and prior authorized services.
3. Services properly rendered to participants as prescribed by the POC are then eligible for payment and the post authorization for payments is released to the fiscal intermediary.
4. The provider then submits claims for approved services to the fiscal intermediary for adjudication and payment.
5. Services provided to the participant not listed on the prior authorization system are rejected and ineligible for payment until all discrepancies are resolved.

Additionally, through Program Integrity's Surveillance and Utilization Review (SUR) process, providers are reviewed to ensure that services are actually provided for claims that are paid. In addition, it is the responsibility of the providers to ensure that the services are provided in accordance with the approved plan of care, maintain adequate supporting documentation of services provided and to complete data entry into the data contractor's database that captures services provided and releases authorization for payment.

- 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:

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v

- 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:

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v

**Appendix I: Financial Accountability**

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**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:

A fiscal/employer agent will provide fiscal management services to self-direction participants, as an administrative activity. Payments will be made to DSW's for family supports services provided to the waiver self-direction participants. The fiscal/employer agent will process participants' employer-related payroll and withhold and deposit the required employment-related taxes.

Oversight is conducted through reports and since this is a contracted agent, oversight is conducted pursuant to all applicable state regulations for contracted services. Reports are submitted bi-weekly and include the amount paid to employees, amount of taxes withheld, and the employee rate of pay. These reports are reviewed to ensure the employee was paid appropriately.

- 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.

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v

**Appendix I: Financial Accountability**

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**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:

## Appendix I: Financial Accountability

### I-3: Payment (5 of 7)

**e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report.  
*Select one:*

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

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

Describe the recoupment process:

## Appendix I: Financial Accountability

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

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

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

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

## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

#### g. Additional Payment Arrangements

**i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

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

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

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

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

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

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

**Appendix I: Financial Accountability**

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

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

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

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

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

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

**Appendix I: Financial Accountability**

**I-4: Non-Federal Matching Funds (2 of 3)**

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

- Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.
- Applicable**



Check each that applies:

**Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

**Other Local Government Level Source(s) of Funds.**

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

**Appendix I: Financial Accountability**

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

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

- None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- The following source(s) are used**  
*Check each that applies:*
  - Health care-related taxes or fees**
  - Provider-related donations**
  - Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

**Appendix I: Financial Accountability**

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

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

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

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings: Do not complete this item.

**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:

	
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**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: ICF/IID**

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	8947.00	18381.00	27328.00	86640.00	4498.00	91138.00	63810.00
2	9497.84	18656.72	28154.56	86640.00	4565.47	91205.47	63050.91
3	9960.36	18936.57	28896.93	86640.00	4633.95	91273.95	62377.02
4	10408.94	19220.61	29629.55	86640.00	4703.46	91343.46	61713.91
5	10981.70	19508.92	30490.62	86640.00	4774.01	91414.01	60923.39

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (1 of 9)**

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	1700		1700
Year 2	1700		1700
Year 3	1700		1700
Year 4	1700		1700
Year 5	1700		1700

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (2 of 9)**

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay estimate is based on total number of days of waiver eligibility of all CC Waiver participants divided by the number of unduplicated participants over the waiver plan year. Current average length of stay information is taken from the CMS 372 report.

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (3 of 9)**

- c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D estimates are based on actual program utilization data for the number of unduplicated recipients and services per recipient for each service in the waiver. An estimated cost per service is derived by multiplying these estimates by actual service rates. This dollar amount is then totaled and divided by the number of unduplicated recipients for an average cost per recipient. A utilization inflation factor is thereby applied to each subsequent year based on program history and other factors.

- 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 is an estimate based on the actual participant expenditures for all other Medicaid services outside of waiver services. This dollar amount is totaled and then divided by the number of waiver recipients to get an estimated average cost. A utilization inflation factor is thereby applied to each subsequent year based on program history and other factors.

To exclude Medicare Part D Pharmacy cost from our cost effectiveness calculations we:

1. Identified all CC Waiver recipients who had dual eligibility for Medicaid and Medicare services.
2. Developed an independent query to identify pharmacy related Part D acute care expenditures.
3. Based on these expenditures, an estimate for average annual Part D expenditure per recipient was derived.
4. Deducted this amount from the average acute care cost per waiver recipient.

- 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 is an estimate based on the actual Medicaid expenditures for all intermediate care facilities for the developmentally disability (ICF/DD). This dollar amount is totaled and then divided by the number of waiver recipients to get an estimated average cost. A utilization inflation factor is thereby applied to each subsequent year based on program history and other factors.

- 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 is an estimate based on the actual Medicaid expenditures for all other Medicaid services provided to citizens residing in intermediate care facilities for the mentally retarded (ICF/MR). This dollar amount is totaled and then divided by the number of waiver recipients to get an estimated average cost. A utilization inflation factor is thereby applied to each subsequent year based on program history and other factors.

To exclude Medicare Part D Pharmacy cost from our cost effectiveness calculations we:

1. Identified all ICF/MR recipients who had dual eligibility for Medicaid and Medicare services
2. Developed an independent query to identify pharmacy related Part D acute care expenditures.
3. Based on these expenditures, an estimate for average annual Part D expenditure per recipient was derived.
4. Deducted this amount from the average acute care cost per ICF/DD recipient.

## **Appendix J: Cost Neutrality Demonstration**

### **J-2: Derivation of Estimates (4 of 9)**

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	
Center-Based Respite	
Support Coordination	
Specialized Medical Equipment and Supplies	
Aquatic Therapy	
Art Therapy	
Environmental Accessibility Adaptations	
Family Support Services	
Family Training	
Hippotherapy/Therapeutic Horseback Riding	
Housing Stabilization Service	
Housing Stabilization Transition Service	

Waiver Services	
Music Therapy	
Sensory Integration	

### Appendix J: Cost Neutrality Demonstration

#### J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Center-Based Respite Total:</b>						64262.85
Center-Based Respite	15 minutes	15	1667.00	2.57	64262.85	
<b>Support Coordination Total:</b>						1639125.00
Support Coordination	monthly	1457	9.00	125.00	1639125.00	
<b>Specialized Medical Equipment and Supplies Total:</b>						53354.00
Specialized Medical Equipment and Supplies	annually	74	1.00	721.00	53354.00	
<b>Aquatic Therapy Total:</b>						481440.00
Aquatic Therapy	15 minutes	118	192.00	21.25	481440.00	
<b>Art Therapy Total:</b>						324510.72
Art Therapy	15 minutes	148	192.00	11.42	324510.72	
<b>Environmental Accessibility Adaptations Total:</b>						358021.56
Environmental Accessibility Adaptations	per adaptation	76	1.00	4710.81	358021.56	
<b>Family Support Services Total:</b>						11181244.55
Family Support Services	15 minutes	1195	2681.00	3.49	11181244.55	
<b>Family Training Total:</b>						3935.00
Family Training	annually	5	1.00	787.00	3935.00	
<b>GRAND TOTAL:</b>						15209891.59
Total Estimated Unduplicated Participants:						1700
Factor D (Divide total by number of participants):						8947.00
Average Length of Stay on the Waiver:						294

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Hippotherapy/Therapeutic Horseback Riding Total:</b>						693953.28
Hippotherapy	15 minutes	118	192.00	21.25	481440.00	
Therapeutic Horseback Riding	15 minutes	118	192.00	9.38	212513.28	
<b>Housing Stabilization Service Total:</b>						26910.91
Housing Stabilization Service	15 minutes	13	137.00	15.11	26910.91	
<b>Housing Stabilization Transition Service Total:</b>						7071.48
Housing Stabilization Transition Service	15 minutes	3	156.00	15.11	7071.48	
<b>Music Therapy Total:</b>						2192.64
Music Therapy	15 minutes	1	192.00	11.42	2192.64	
<b>Sensory Integration Total:</b>						373869.60
Sensory Integration	15 minutes	30	521.00	23.92	373869.60	
<b>GRAND TOTAL:</b>						15209891.59
Total Estimated Unduplicated Participants:						1700
Factor D (Divide total by number of participants):						8947.00
Average Length of Stay on the Waiver:						294

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

#### d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Center-Based Respite Total:</b>						68547.04
Center-Based Respite	15 minutes	16	1667.00	2.57	68547.04	
<b>Support Coordination Total:</b>						1887517.50
Support Coordination	monthly	1507	10.00	125.25	1887517.50	
<b>GRAND TOTAL:</b>						16146335.79
Total Estimated Unduplicated Participants:						1700
Factor D (Divide total by number of participants):						9497.84
Average Length of Stay on the Waiver:						294

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Specialized Medical Equipment and Supplies Total:</b>						54842.36
Specialized Medical Equipment and Supplies	per piece	76	1.00	721.61	54842.36	
<b>Aquatic Therapy Total:</b>						497760.00
Aquatic Therapy	15 minutes	122	192.00	21.25	497760.00	
<b>Art Therapy Total:</b>						335473.92
Art Therapy	15 minutes	153	192.00	11.42	335473.92	
<b>Environmental Accessibility Adaptations Total:</b>						367443.18
Environmental Accessibility Adaptations	per adaptation	78	1.00	4710.81	367443.18	
<b>Family Support Services Total:</b>						11780072.71
Family Support Services	15 minutes	1259	2681.00	3.49	11780072.71	
<b>Family Training Total:</b>						3935.00
Family Training	annually	5	1.00	787.00	3935.00	
<b>Hippotherapy/Therapeutic Horseback Riding Total:</b>						717477.12
Hippotherapy	15 minutes	122	192.00	21.25	497760.00	
Therapeutic Horseback Riding	15 minutes	122	192.00	9.38	219717.12	
<b>Housing Stabilization Service Total:</b>						33121.12
Housing Stabilization Service	15 minutes	16	137.00	15.11	33121.12	
<b>Housing Stabilization Transition Service Total:</b>						9428.64
Housing Stabilization Transition Service	15 minutes	4	156.00	15.11	9428.64	
<b>Music Therapy Total:</b>						4385.28
Music Therapy	15 minutes	2	192.00	11.42	4385.28	
<b>Sensory Integration Total:</b>						386331.92
Sensory Integration	15 minutes	31	521.00	23.92	386331.92	
<b>GRAND TOTAL:</b>						16146335.79
Total Estimated Unduplicated Participants:						1700
Factor D (Divide total by number of participants):						9497.84
Average Length of Stay on the Waiver:						294



**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (7 of 9)**

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Center-Based Respite Total:</b>						72831.23
Center-Based Respite	15 minutes	17	1667.00	2.57	72831.23	
<b>Support Coordination Total:</b>						1972687.50
Support Coordination	monthly	1575	10.00	125.25	1972687.50	
<b>Specialized Medical Equipment and Supplies Total:</b>						57007.19
Specialized Medical Equipment and Supplies	annually	79	1.00	721.61	57007.19	
<b>Aquatic Therapy Total:</b>						514080.00
Aquatic Therapy	15 minutes	126	192.00	21.25	514080.00	
<b>Art Therapy Total:</b>						346437.12
Art Therapy	15 minutes	158	192.00	11.42	346437.12	
<b>Environmental Accessibility Adaptations Total:</b>						381575.61
Environmental Accessibility Adaptations	annually	81	1.00	4710.81	381575.61	
<b>Family Support Services Total:</b>						12388257.56
Family Support Services	15 minutes	1324	2681.00	3.49	12388257.56	
<b>Family Training Total:</b>						4722.00
Family Training	annually	6	1.00	787.00	4722.00	
<b>Hippotherapy/Therapeutic Horseback Riding Total:</b>						741000.96
Hippotherapy	15 minutes	126	192.00	21.25	514080.00	
Therapeutic Horseback Riding	15 minutes				226920.96	
<b>GRAND TOTAL:</b>						16932608.73
Total Estimated Unduplicated Participants:						1700
Factor D (Divide total by number of participants):						9960.36
Average Length of Stay on the Waiver:						294

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		126	192.00	9.38		
<b>Housing Stabilization Service Total:</b>						41401.40
Housing Stabilization Service	15 minutes	20	137.00	15.11	41401.40	
<b>Housing Stabilization Transition Service Total:</b>						9428.64
Housing Stabilization Transition Service	15 minutes	4	156.00	15.11	9428.64	
<b>Music Therapy Total:</b>						4385.28
Music Therapy	15 minutes	2	192.00	11.42	4385.28	
<b>Sensory Integration Total:</b>						398794.24
Sensory Integration	15 minutes	32	521.00	23.92	398794.24	
<b>GRAND TOTAL:</b>						16932608.73
Total Estimated Unduplicated Participants:						1700
Factor D (Divide total by number of participants):						9960.36
Average Length of Stay on the Waiver:						294

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (8 of 9)**

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 4**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Center-Based Respite Total:</b>						72831.23
Center-Based Respite	15 minutes	17	1667.00	2.57	72831.23	
<b>Support Coordination Total:</b>						2035312.50
Support Coordination	monthly	1625	10.00	125.25	2035312.50	
<b>Specialized Medical Equipment and Supplies Total:</b>						58450.41
Specialized Medical Equipment and Supplies	per piece	81	1.00	721.61	58450.41	
<b>Aquatic Therapy Total:</b>						
<b>GRAND TOTAL:</b>						17695189.75
Total Estimated Unduplicated Participants:						1700
Factor D (Divide total by number of participants):						10408.94
Average Length of Stay on the Waiver:						294

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						530400.00
Aquatic Therapy	15 minutes	130	192.00	21.25	530400.00	
<b>Art Therapy Total:</b>						357400.32
Art Therapy	15 minutes	163	192.00	11.42	357400.32	
<b>Environmental Accessibility Adaptations Total:</b>						390997.23
Environmental Accessibility Adaptations	annually	83	1.00	4710.81	390997.23	
<b>Family Support Services Total:</b>						13005799.10
Family Support Services	15 minutes	1390	2681.00	3.49	13005799.10	
<b>Family Training Total:</b>						4722.00
Family Training	annually	6	1.00	787.00	4722.00	
<b>Hippotherapy/Therapeutic Horseback Riding Total:</b>						764524.80
Hippotherapy	15 minutes	130	192.00	21.25	530400.00	
Therapeutic Horseback Riding	15 minutes	130	192.00	9.38	234124.80	
<b>Housing Stabilization Service Total:</b>						49681.68
Housing Stabilization Service	15 minutes	24	137.00	15.11	49681.68	
<b>Housing Stabilization Transition Service Total:</b>						9428.64
Housing Stabilization Transition Service	15 minutes	4	156.00	15.11	9428.64	
<b>Music Therapy Total:</b>						4385.28
Music Therapy	15 minutes	2	192.00	11.42	4385.28	
<b>Sensory Integration Total:</b>						411256.56
Sensory Integration	15 minutes	33	521.00	23.92	411256.56	
<b>GRAND TOTAL:</b>						17695189.75
Total Estimated Unduplicated Participants:						1700
Factor D (Divide total by number of participants):						10408.94
Average Length of Stay on the Waiver:						294

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (9 of 9)**

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 5**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Center-Based Respite Total:</b>						77115.42
Center-Based Respite	15 minutes	18	1667.00	2.57	77115.42	
<b>Support Coordination Total:</b>						2129250.00
Support Coordination	monthly	1700	10.00	125.25	2129250.00	
<b>Specialized Medical Equipment and Supplies Total:</b>						61336.85
Specialized Medical Equipment and Supplies	annually	85	1.00	721.61	61336.85	
<b>Aquatic Therapy Total:</b>						554880.00
Aquatic Therapy	15 minutes	136	192.00	21.25	554880.00	
<b>Art Therapy Total:</b>						372748.80
Art Therapy	15 minutes	170	192.00	11.42	372748.80	
<b>Environmental Accessibility Adaptations Total:</b>						409840.47
Environmental Accessibility Adaptations	annually	87	1.00	4710.81	409840.47	
<b>Family Support Services Total:</b>						13763690.99
Family Support Services	15 minutes	1471	2681.00	3.49	13763690.99	
<b>Family Training Total:</b>						4722.00
Family Training	annually	6	1.00	787.00	4722.00	
<b>Hippotherapy/Therapeutic Horseback Riding Total:</b>						799810.56
Hippotherapy	15 minutes	136	192.00	21.25	554880.00	
Therapeutic Horseback Riding	15 minutes	136	192.00	9.38	244930.56	
<b>Housing Stabilization Service Total:</b>						57961.96
Housing Stabilization Service	15 minutes	28	137.00	15.11	57961.96	
<b>GRAND TOTAL:</b>						18668889.85
Total Estimated Unduplicated Participants:						1700
Factor D (Divide total by number of participants):						10981.70
Average Length of Stay on the Waiver:						294

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Housing Stabilization Transition Service Total:</b>						9428.64
Housing Stabilization Transition Service	15 minutes	4	156.00	15.11	9428.64	
<b>Music Therapy Total:</b>						4385.28
Music Therapy	15 minutes	2	192.00	11.42	4385.28	
<b>Sensory Integration Total:</b>						423718.88
Sensory Integration	15 minutes	34	521.00	23.92	423718.88	
<b>GRAND TOTAL:</b>						1866889.85
Total Estimated Unduplicated Participants:						1700
Factor D (Divide total by number of participants):						10981.70
Average Length of Stay on the Waiver:						294