participant in accessing needed and appropriate services through the ROW and other available programs, ensuring that no lapse in necessary services occurs for which the participant is eligible. There is no denial of services, only the transition to a different payment option. The participant and Support Coordinator are provided with a written notice explaining the reason for the action and citing the policy reference.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	5	
Year 2	10	
Year 3	15	
Year 4	30	
Year 5	60	

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☐ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assis the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☐ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☐ **Hire staff common law employer**
☐ **Verify staff qualifications**
☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

It is included in the FMS contract.

The cost of criminal background checks are paid for by DHH.

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☐ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☐ **Determine staff wages and benefits subject to State limits**

- [ ] **Schedule staff**
- [ ] **Orient and instruct staff in duties**
- [ ] **Supervise staff**
- [ ] **Evaluate staff performance**
- [ ] **Verify time worked by staff and approve time sheets**
- [ ] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that th participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [ ] **Determine the amount paid for services within the State's established limits**
- [ ] **Substitute service providers**
- [ ] **Schedule the provision of services**
- [ ] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [ ] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [ ] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. **Participant Exercise of Budget Flexibility.** *Select one*:

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Louisiana Medicaid Eligibility Manual states, "Every applicant for and participant of Louisiana Medicaid benefits has the right to appeal any agency action or decision and has the right to a fair hearing of the appeal in the presence of an impartial hearing officer". (Medicaid Eligibility Manual, T-100/Fair Hearings/General Information).

Both applicants and recipients are afforded the right to request a fair hearing for services which have been denied, not acted upon with reasonable promptness, suspended, terminated, reduced or discontinued, La. R.S. 46:107. A person may file an administrative appeal to the Division of Administrative Law in the Louisiana Department of Health and Hospitals regarding the following determinations:

1) A finding by the office that the person does not qualify for system entry;
2) Denial of entrance into a home and community-based service waiver;
3) Involuntary reduction or termination of a support or service;
4) Discharge from the system; and/or

5) Other cases as stated in office policy or as promulgated in regulation.

During the initial assessment process, which must begin within 7 calendar days of referral/linkage of the participant to the Support Coordination agency, the Support Coordinator will give a participant and his/her legal representatives an OCDD information sheet entitled "Rights and Responsibilities for Applicants/Participants of a Home and Community Based Waiver" which includes information on how to file a complaint, grievance, or appeal with the Louisiana Department of Health and Hospitals. A copy of this information sheet is kept in the participant's record at the Support Coordination agency's physical location of business. In addition, the Plan of Care contains a section that addresses the right to a fair hearing within ten days, and how to request a fair hearing, if the participant and his/her legal representatives disagree with any decision rendered regarding approval of the plan. Dated signatures of the participant, his/her legal representatives, and a witness are required on this section. Copies of the service plan, including this section are kept in the appropriate OCDD Regional Waiver Supports and Services Offices and/or Human Services Authorities or Districts and the Support Coordination agency's physical location of business.

If an individual does not receive the Louisiana Medicaid Long Term Care Choice of Service form offering the choice of home and community based services as an alternative to institutional care, and/or the Freedom of Choice form for case management and/or direct service providers, he/she or his/her legal representatives may request a fair hearing with the Division of Administrative Law in the Louisiana Department of Health and Hospitals in writing, by phone or e-mail. The OCDD Regional Waiver Supports and Services Office or Human Services Authority or District is responsible for giving information to the individual and his/her legal representatives of how to contact the Louisiana Department of Health and Hospitals Division of Administrative Law by writing, phone or e-mail, and how to contact The Advocacy Center by phone or mail. This is done at the time of enrollment and at any other time the participant and his/her legal representative requests the number(s).

BHSF utilizes the Adequate Notice of Home and Community Based Services (Waiver) Decision Form 18-W to notify individuals by mail if they have not been approved for Home and Community Based Waiver services due to financial ineligibility. A separate page is attached to this form entitled "Your Fair Hearing Rights". This page contains information on how to request a fair hearing, how to obtain free legal assistance, and a section to complete if the individual is requesting a fair hearing. If the participant does not return this form, it does not prohibit his right to appeal and receive a fair hearing.

In accordance with 42CFR 431.206, 210 and 211, participants receiving waiver services, and their legal representatives are sent a certified letter with return receipt to ensure the participant receives it by the appropriate OCDD Regional Waiver Supports and Services Office or Human Services Authority or District providing 10 days advance and adequate notification of any proposed denial, reduction, or termination of waiver services. Included in the letter are instructions for requesting a fair hearing, and notification that an oral or written request must be made within ten days of receipt of a proposed adverse action by the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District in order for current waiver services remain in place during the appeal process. If the appeal request is not made within ten days, but is made within thirty days, all Medicaid waiver services are discontinued on the eleventh day; services that are continued until the final decision is rendered are not billable under the Medicaid waiver. If the final decision of the Administrative Law Judge is favorable to the appellant, services are re-implemented from the date of the final decision. An appeal hearing is not granted if the appeal request is made later than thirty days following receipt of a proposed adverse action sent by the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District. Once a request for an appeal is received, the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District must submit the request to the Division of Administrative Law no later than seven calendar days after receipt. A copy of the letter and the response/request is kept in the participant's record at the appropriate OCDD Regional Waiver Supports and Services Office or Human Services Authority or District.

During an appeal request and/or fair hearing the Support Coordinator provides:
Assistance as requested by the participant and his/her legal representatives;
Documentation in progress notes of the status of the appeal; and
Information the participant and his/her legal representatives need to complete the appeal or prepare for a fair hearing.

Anyone requesting an appeal has the right to withdraw the appeal request at any time prior to the hearing. The appellant may contact the Division of Administrative Law directly, or may request withdrawal through the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District. Requests for withdrawal are kept in the participant's record at the appropriate OCDD Regional Waiver Supports and Services Office or Human Services Authority or District.

Enrolled providers of waiver services provide participants and their legal representatives notice in writing at least fifteen days prior to the transfer or discharge from the provider agency with the proposed date of the transfer/discharge, the reason for the action, and the names of personnel available to assist the participant throughout the process. The enrolled provider of waiver services must also provide the participant and his/her legal representatives with information on how to request an appeal of a decision for involuntary discharge. A copy of the notice of intent to transfer/discharge, and information that was provided on how to access the appeal process is kept in the participant's record at the enrolled provider of waiver services' physical location of business.

All Administrative Hearings are conducted in accordance with the Louisiana Administrative Procedure Act, La. R.S. 49:950 et seq. Any party may appear and be heard at any appeals proceeding through an attorney at law or through a designated representative.

The operating agency will provide WCS with quarterly reports of those persons who have been notified of appeal rights when waiver services have been denied, terminated or reduced. Included will be dates of notification and reasons prompting notification.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

○ **No. This Appendix does not apply**

● **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

○ **No. This Appendix does not apply**

● **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Bureau of HealthServices Financing, Health Standards Section (HSS) is responsible for the operation of the grievance/complaint system.

The OCDD is responsible for receiving, reporting, and responding to customer complaints received for participants supported through their office, including those supported through the waiver.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The OCDD is responsible for receiving, reporting and responding to customer complaints received for people supported through their office including those supported through the ROW. A complaint is a written or verbal statement expressing concern or dissatisfaction, which calls for action/resolution. Each OCDD entity including OCDD Regional Waiver Supports and Services Office or Human Services Authority or District and State Office are responsible for receiving, reporting, and responding to customer complaints. Each OCDD entity is responsible for training their staff, participants, their families, and providers regarding OCDD's policy on Customer Complaints. A complaint may be made in person or by phone, fax, e-mail or mail to an OCDD entity. When a complaint is received by OCDD the complaint is triaged to determine if the complaint can be resolved by OCDD or if the complaint needs to be referred to another agency (Health Services Finance, Program Integrity, Protective Services etc.) for action/resolution. The initiation of the complaint review and follow-up occurs within two business days of receipt of the complaint. Actions to resolve the complaint will be completed within thirty calendar days of receipt of the complaint. A written response describing the actions in response to the complaint, is mailed to the complainant within five (5) business days of the complaint resolution/action. OCDD will continue to follow up with other agencies regarding complaint action/resolution. All complaints are entered into a data base for tracking of complaints and quality management purposes.

The Bureau of Health Services Financing, Health Standards Section (HSS) is responsible for the operation of the Home and Community Based Waiver Complaint Line that involves complaints against licensed providers.

• The HSS State Office complaint line is the central point of entry for all complaints regarding the waiver. The HSS maintains an established complaint line with a toll free number for participants and their legal representatives.

• The nature and scope of the complaint is at the discretion of the individual registering the complaint.

• The complaint line number is printed on business cards, brochures, and fact sheets. It is given to participants and their legal representative(s) at intake by their Support Coordinator. During the pre-certification visit the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District staff checks to make sure that the information has been given to them. The Support Coordinator reviews the information during quarterly face to face visits, and each year at the annual service plan team meeting, or whenever it is requested by the participant and his/her legal representative(s).

• HSS and OCDD Regional Waiver Supports and Services Office or Human Services Authority or District staff, as well as support agencies such as Families Helping Families distribute the HSS complaint line information when assisting participants and their legal representative(s). Direct service providers are also required to give the complaint line number to all participants.

• Support Coordinators are responsible for informing participants and their legal representative(s) initially, annually or whenever information about the system is requested that filing a grievance or complaint is not a pre-requisite or substitute for a Fair Hearing. OCDD Regional Waiver Supports and Services Office or Human Services Authority or District staff checks to make sure that this information has

been relayed to them during the pre-certification visit.

• If the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District or State Office staff is contacted by a participant/legal representative(s), other state agency, support coordinator or provider wishing to file a complaint, the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District staff will refer the complaint by fax to the HSS complaint line within 24 hours for tracking and distribution.

• HSS triages all complaints in the following manner:

o. Provider non-compliance licensing issues are resolved by HSS.

o. Complaints identified as abuse, neglect, exploitation or extortion are referred immediately to the appropriate bureau of protective services (Child Protective Services, Adult Protective Services, or Elderly Protective Servcies).

o. All other types of complaints are referred to OCDD State Office for incident resolution. Complaints identified as critical events or incidents are investigated by the appropriate office within thirty days of receipt of such report.

• Pursuant to Louisiana Revised Statutes 40:2009.14 if the complaint involves provider non-compliance, HSS will investigate by telephone, provider report, or at the time of the next scheduled visit to the provider's facility and send a written report to the complainant within 45 days of receipt of the completed investigation, if a response to the complaint is requested by the complainant.

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).

Critical events or incidents that are required to be reported for review and follow-up action by the appropriate authority are:

• Abuse (adult/elderly): The infliction of physical or mental injury on a participant by other parties. (Louisiana Revised Statutes 15:1503).

• Abuse (child): Any acts which seriously endanger the physical, mental, or emotional health and safety of a child (Louisiana Children's Code, Article 1003).

• Exploitation: The illegal or improper use or management of an aged person's or disabled adult's funds, assets or property (Louisiana Revised Statutes 15:1503).

• Extortion: The acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority. (Louisiana Revised Statutes 15:1503).

• Neglect (adult/elderly): The failure, by a caregiver responsible for an adult's care or by other parties, or by the adult participant's action or inaction to provide the proper or necessary support or medical, surgical, or any other care necessary for his well-being (Louisiana Revised Statutes 15:1503).

• Neglect (child): The refusal or failure of a parent or caretaker to supply the child with necessary food, clothing, shelter, care, treatment or counseling for an injury, illness, or condition of the child, as a result of which the child's physical, mental, or emotional health and safety is substantially threatened or impaired (Children's Code Article 1003).

• Fall: A participant is either found on the floor or ground (un-witnessed event), or the participant comes to rest on the floor or ground unintentionally, assisted or unassisted (witnessed).

• Involvement with Law Enforcement: Occurs when a participant, his/her staff, or others responsible for the participant's care, are involved directly or indirectly in an alleged criminal manner, resulting in law enforcement actions.

• Loss or Destruction of Home: Damage to or loss of the participant's home that causes harm or the risk of harm to the participant.

• Major Behavioral Incident: an incident engaged in by a participant that is alleged, suspected, or witnessed by the reporter that can reasonably be expected to result in harm, or that may affect the safety and well-being of the participant (e.g., attempted suicide, suicidal threats, self-endangerment, elopement/missing, self-injury, property destruction, offensive sexual behavior, sexual aggression, physical aggression).

• Major Illness: Any substantial change in health status, illness, or sickness (suspected or confirmed) which requires unscheduled treatment, or other medical intervention by a physician, nurse, dentist, or other licensed health care providers. Major illnesses include but are not limited to bowel obstruction, decubitis, pneumonia, or seizures.

• Major Injury: Any suspected or confirmed wound or injury to a participant of known or unknown origin requiring medical attention by a physician, nurse, dentist, or any licensed heal care provider.

• Major Medication Incident: The administration or self-administration of medication in an incorrect form, not as prescribed or ordered, or to the wrong person, or the failure to administer or self-administer a prescribed medication, which requires or results in medical attention by a physician, nurse, dentist, or any licensed health care provider. Major medication incidents include staff error, pharmacy error, person error, medication non-adherence, and family error.

• Healthcare Admission: The admission of a participant to a hospital or other health care facility for the purpose of receiving medical care or other treatments, etc. Reportable healthcare admissions include acute care facility, emergency room, nursing home, psychiatric hospital, rehabilitation facility, respite center/supports and services center.

• Restraint Use: Any personal, physical, chemical, or mechanical intervention used to control acute, episodic behavior that restricts movement or function of a participant or a portion of a participant's body (OCDD Policy # 701 Restraints and Seclusion).

• Self-neglect: The failure by the participant's action or inaction to provide the proper or necessary supports or other medical, surgical, or any other care necessary for his/her own well-being. (Louisiana Revised Statutes 15:1503).

• Death: This is determined by the physician or coroner who issues the death certificate for a participant.

Individuals and entities who must report critical incidents and the reporting method(s) employed are:

• Participant and/or family member(s):
  o Report as soon as possible to the direct service provider and/or support coordination agency.

• Direct Service Provider (DSP) staff:
  o Must immediately take the necessary action required to assure the participant is protected from further harm and respond to any emergency needs of the participant.
  o Must verbally report all critical incidents immediately upon discovery or within 2 hours of the incident to the Support Coordinator/Agency after taking all necessary actions to protect the participant from further harm and responding to the emergency needs of the participant.
  o Must fax or hand deliver a copy of the completed Critical Incident Report (hard copy) to the Support Coordinator/Agency as soon as possible, but no later than 24 hours of the incident occurrence or discovery.
  o Submit a follow-up report regarding the Critical Incident to the Support Coordinator/Agency by the close of the third business day following the initial report.

• Support Coordinator:
  o When Support Coordinator discovers an incident, the Support Coordinator must contact the direct service provider within 2 hours of discovery and inform the provider of the incident. Must collaborate to assure that the participant is protected from further harm and assure that emergency actions are taken.
  o Enters the critical incident information into the web-based Online Tracking System (OTIS) by close of the next business day.
  o Enters follow-up case notes within 6 business days after the initial critical incident is received from the direct service provider or discovery by the support coordinator.

• OCDD Regional Office /Human Service District/Authority CSRA, or designee:
  o Review all critical incident reports on a daily basis
  o Immediately or within 24 hours notify verbally and in writing (via e-mail) the State Office Quality Management Designee, if the incident involves the death or the arrest of a participant or when the critical incident involves the abuse/neglect of a participant and results in the involvement of Law Enforcement.

• OCDD Regional Office /Human Service District/Authority Staff:
  o When staff suspect or become aware that a Critical Incident meets the definition of abuse, neglect, exploitation, or extortion, immediately report the case to the appropriate protective agency (e.g., CPS, APS/EPS).
  o Assure that activities occur within required timelines, including closure of the critical incident within thirty days, unless an extension has been granted

• OCDD Quality Management Section:
  o Upon receipt of e-mail or verbal notification involving the death of a participant, the arrest of a participant, or of the abuse or neglect of a participant involving law enforcement, immediately, but no later than twenty-four hours, notify in writing, sending via e-mail to all the

following:

- DHH Deputy Chief of Staff;
- DHH Bureau of Media and Communication;
- OCDD Assistant Secretary or Designee;
- OCDD Deputy Assistant Secretary;
- Executive Director of Waiver Supports and Services;
- Executive Director of Community Services;
- OCDD Quality Management Staff;
- Other OCDD State and Regional Office/Human Services District/Authority Staff as deemed appropriate

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.

• A Rights and HIPAA form are completed during the initial Single Point of Entry Determination Process for System Entry intake interview with the individual and his/her legal representatives. A Support Profile is completed during the intake interview that addresses issues concerning the individual's well-being, health, safety, and security.

• During the initial assessment and Plan of Care development process, the Support Coordinator explains the participant's right to be free from abuse and neglect and gives the number for the HSS complaint line to the participant and his/her legal representatives, reviews the participant's rights and responsibilities and gives them a copy of the OCDD Rights and Responsibilities for Applicants/Recipients of a Home and Community Based Waiver. The Support Coordinator also checks that the participant and his/her legal representative(s) have the HSS complaint line number at the quarterly face-to-face visits, or whenever it is requested.

• The participant/family member has a responsibility for reporting critical incidents.

• During the Pre-Certification Visit (after the assessment process and Plan of Care have been completed, but prior to services being initiated) the OCDD Regional Waiver Supports and Services Offices or Human Services Authority or District Staff will review all information, including information about abuse and neglect, with the participant and his/her legal representatives; make sure that they have phone numbers for the HSS complaint line, the OCDD Regional Waiver Supports and Services Offices or Human Services Authority or District, and the Support Coordination agency for reporting purposes; and that they understand their rights and responsibilities and have been given a copy of the OCDD Rights and Responsibilities for Applicants/Participants of a Home and Community Based Waiver.

When there is a change in the participant's services, choice of self-direction, POC, etc., the participant's Support Coordinator reviews and explains the information with the participant/family. The Support Coordinator is available at any point in time to train/education the participant/family regarding issues/needs that may arise.

• Each direct service provider is required by licensing regulations to have a written orientation program for participants being admitted to their programs that include participant rights and responsibilities, and grievance and appeal procedures that contain information on abuse and neglect.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critica 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.

Reports/Evaluation of Reports/Investigations/Timeframes:

• Direct Support Provider:

o Once notification of a Critical Incident is received by the provider agency, within two (2) hours of discovery, they must inform the support coordinator of the incident. The provider must assure that the participant is protected from further harm and respond to any emergency needs of the participant.

o If abuse/neglect/exploitation/extortion is suspected, provider must immediately contact the appropriate protective service agency (CPS, APS/EPS). The provider must cooperate with the appropriate protective service agency once the agency has been notified and an investigation commences. The provider is required to provide relevant information, records, and access to members of the agency conducting the investigation.

o The provider participates in planning meetings to resolve the Critical Incident or to develop strategies to prevent or mitigate the likelihood of similar incidents in the future.

o The provider tracks Critical Incidents in order to identify remediation needs and quality improvement goals and to determine the effectiveness of strategies employed for incident resolution.

• Support Coordinator:

o Receives Critical Incident Report from provider within 24 hours of the incident. Enter the critical incident information into the web-based Online Tracking System (OTIS) by close of the next business day. Enter follow-up case notes within 6 business days after the initial critical incident is received from the direct service provider or discovery by the support coordinator. The support coordinator must collaborate with the provider to assure that the participant is protected from further harm and respond to any emergency needs of the participant.

o If abuse/neglect/exploitation/extortion is suspected, support coordinator must immediately contact the appropriate protective service agency (CPS, APS/EPS).

o Convene planning meetings that may be required to resolve the critical incident or to develop strategies to prevent or mitigate the

likelihood of similar critical incidents from occurring in the future.

o Obtain the participant summary from the web-based Online Tracking System (OTIS) after closure by the OCDD Regional Office or Human Service Authority/District and forward to the provider and participant within 15 days.

o Track critical incidents to identify required remediation actions and quality improvement goals, and to determine the effectiveness of strategies employed.

- OCDD Regional Office /Human Service District/Authority CSRA, or designee:

o On a daily basis, the CSRA, or designee, will review all new incoming critical incident reports, determine the report priority level (i.e., urgent or non-urgent), and assign the report to regional staff immediately or within 1 business day.

o Close cases after all needed follow-up has occurred and all necessary data has been entered into OTIS (supervisor review and closure).

o Tracks Critical Incidents by report to identify remediation needs and quality improvement goals and to determine the effectiveness of the strategies employed to assure resolution to the Critical Incident Report.

o The CSRA will sample Critical Incidents to review for adherence to policy including a review to determine if all necessary actions were taken to address and resolve Critical Incidents.

- OCDD Regional Office /Human Service District/Authority Staff:

o Upon receipt of the notification of the Critical Incident from the CSRA, staff will continue case follow-up which includes providing technical assistance to the support coordinator, requesting any additional information from the support coordinator as needed, review to assure that all necessary information has been entered by the support coordinator into the web-based Online Tracking System (OTIS).

o If staff suspect or become aware that a Critical Incident meets the definition of abuse, neglect, exploitation or extortion, staff must immediately report the incident to the appropriate protective service agency.

o Make timely referrals to other agencies as necessary.

o Staff will complete the participant summary and assure closure of the Critical Incident within 30 days.

- CPS (ages 0 to 17):

o Upon receipt of an allegation or report of abuse, neglect or exploitation involving a child by a family member or legal guardian, CPS investigates based upon their internal policy and guidelines. Cases are scheduled for completion/closure within 90 days.

o If the perpetrator/accused is a direct service provider staff person, a report is made to Health Standards Section for the investigation.

- APS/EPS(ages 18 and above):

o Upon receipt of an allegation or report of abuse, neglect, exploitation, or extortion involving an adult/elderly participant by a family member or legal guardian, APS/EPS investigates based upon their internal policy and guidelines. Cases are scheduled for completion/closure within 90 days.

o If the perpetrator/accused is a direct service provider staff person, APS/EPS investigates based upon their internal policy and guidelines. Cases are scheduled for completion/closure within 30 days.

- Health Standards Section:

o Upon receipt of an allegation or report of abuse, neglect, exploitation, or extortion by a direct service provider staff, Health Standards Section investigates based upon their internal policy and guidelines. Cases are scheduled for completion/closure within 30 days.

- Law Enforcement:

o Upon receipt of an allegation or report of abuse, neglect, or exploitation of a child that involves a direct service provider staff, law enforcement will investigate within their timeframe for closure of the case.

- OCDD State Office (Quality Section):

o Within 24 hours or immediately upon discovery, OCDD Regional Office or Human Service Authority or District will notify both verbally and in writing (via e-mail) the OCDD State Office Quality Management Designee when critical incidents involve the death or arrest of a participant, or when critical incidents of abuse/neglect of a participant results in the involvement of Law Enforcement.

o Provides technical assistance to the OCDD Regional Office or Human Service Authority or District as needed. OCDD State Office (Quality Section) identifies necessary remediation to be taken by the direct service provider, support coordinator/agency, and OCDD Regional Office or Human Service Authority or District staff.

o Identifies and reviews trends and patterns to identify potential quality enhancement goals and utilizes the critical incident data to determine the effectiveness of OCDD Quality Enhancement strategies.

Process and timeframes for informing the participant/family/legal representative and other relevant parties of the investigation results:

- The OCDD Regional Office or Human Service Authority or District staff completes the participant summary for all Critical Incidents within 30 days of the Critical Incident.

- The support coordinator obtains the participant summary and forwards a copy to the participant and direct service provider within 15 days of closure by the OCDD Regional Office or Human Service Authority or District.

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.

OCDD is the State entity responsible for overseeing the operation of the incident management system.

A multi-agency Memorandum of Understanding delineates the responsibility for oversight of the reporting and response to critical incidents or events that affect waiver participants. Agencies include Medicaid, OCDD, and Human Services Districts and Authorities.

The process for the oversight agency to communicate information and findings to the Medicaid agency:

• OCDD provides the State Medicaid Agency quarterly reports which include all Critical Incidents.

Methods for overseeing the operation of the incident management system, including how data are collected, compiled, and used to prevent re-occurrence:

• Periodically, the OCDD Region office/Human Services District/Authority shall select a sample of critical incidents to review for adherence to policy including a review to determine if all necessary actions were taken to address and resolve critical incidents.

• A sample of critical incidents to review for adherence to policy, including a review to determine if all necessary actions were taken to address/resolve critical incidents is selected.

• OCDD aggregates critical incident data and analyze the data to identify trends and patterns;

• OCDD reviews reports of the trends and patterns to identify potential quality enhancement goals;

• OCDD utilizes critical incident data to determine the effectiveness of quality enhancement strategies.

• OCDD utilizes the information and data collected on critical incidents for quality management purposes, including but not limited to the following:

o Development and review of reports to assure that follow-up and case closure of critical incidents occur according to this policy on an on-going basis for individual cases and quality review of aggregate data

o Quarterly analysis of data to identify trends and patterns for effective program management that ensures the safety and well-being of people receiving OCDD supports and services and ensures that people receive quality supports and services from OCDD

o Annual analysis of data to determine the effectiveness of quality enhancement goals and activities; and

o Identification of participants who experience frequent critical incidents and will need strategies to mitigate risk included in their Plan of Care on an on-going basis by support coordination agencies as they perform their quarterly Plan of Care reviews.

Frequency of oversight activities:

WCS reviews critical incident reports from the operating agency on a quarterly basis to determine if they were resolved appropriately and timely and to determine if there are any trends and patterns that indicate further action is needed. WCS also monitors the data reports to see if remediation activities implemented in the previous quarter were effective in improving data results for the current period. If remediation activities were not effective, the SMA will meet with the operating agency to address any changes needed to remediation strategies in order to improve results. The SMA will continue to follow up with the operating agency to evaluate remediation for effectiveness.

WCS also conducts a look-behind review of critical incidents to ensure remediation activities occurred correctly and timely; if necessary steps were taken in response to reported incidents; and if appropriate referrals to HSS and protective services/law enforcement were made.

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).

Restraint: any physical, chemical, or mechanical intervention used to control acute, episodic behavior that restricts movement or function of the person or a portion of the person's body, must be reported as a critical incident. Categories of restraint use:

•Behavioral: restraints used to suppress a person's behavior and do not include restraints utilized when conducting a medical treatment. May be planned or unplanned. May involve personal, mechanical, or chemical restraints. Includes a protective hold.

•Medical: rstraints applied as a health related protection that are prescribed by a licensed physician, licensed dentist, or licensed podiatrist. Used when absolutely necessary during the conduct of a specified medical or surgical procedure or when absolutely necessary for the protection of the person during the time that a medical condition exists. May be planned or unplanned. May involve personal, mechanical, or chemical restraints. The appropriate use of "light sedation" is not considered a medical restraint.

The operating agency provides Bureau of Health Services Financing (Medicaid agency) with aggregate data and reports which are inclusive of any reported restraint use.
Seclusion is not permitted.

•Enrolled providers of waiver services are prohibited by licensing regulations to inflict corporal punishment, use chemical restraints, psychological abuse, verbal abuse, seclusion, forced exercise, mechanical restraints, any procedure which denies food, drink, or use of rest room facilities and any cruel, severe, unusual or unnecessary punishment.

•The only restraint that may be used in an emergency is a protective hold (falls under the definition of a behavioral restraint).

•Protective holds are only to be used in an emergency to prevent a person from causing harm to self or others and after other, less restrictive interventions/strategies have failed. Protective holds may only be implemented by trained staff and of short duration. [Louisiana Revised Statutes 40.2006(E)(2) & 40.2120.11-40:2120.16 which cover the broad range of agencies, programs, and facilities who are subject to the Statutes.]

•Pursuant to DHH Policy #0028-04, the Office for Citizens with Developmental Disabilities has a Policy on Restraint and Seclusion (#701). This policy covers:

o Individual right to be free from restraints imposed for the purpose of coercion, discipline or convenience of or retaliation by staff;

o When restraints are necessary in an emergency situation where the behavior of the individual represents an imminent risk of injury to the individual or others;

o Staff training and competence in methods for minimizing the use of restraint and safely applying restraint and in policies concerning the use of restraint.

•Enrolled providers of waiver services are required by licensing regulations to ensure that non-intrusive, positive approaches to address the meaning/origin of behaviors that could potentially cause harm to self or others.

•Direct care staff are required to have initial and annual training in the management of aggressive behavior, this includes acceptable and prohibited responses, crisis de-escalation, and safe methods for protecting the person and staff, including techniques for physically holding a person if necessary. When a participant becomes angry, verbally aggressive or highly excitable, staff will utilize this training.

•If a protective hold must be utilized, direct care staff will notify the Support Coordinator verbally immediately or within two hours of discovery and report in writing via Critical Incident Report within 24 hours, following appropriate reporting procedures.

•The Support Coordinator will contact the participant and his/her legal representatives within 24 hours of receiving the incident report involving a physical hold. Changes to the service plan or living situation will be considered to support the person"s safety and well-being. Follow-up visits with the participant and his/her legal representatives are conducted and include questions about any actions taken by a service provider that may qualify as unauthorized use or misapplication of physical restraints.

•Unauthorized use of restraints is detected through the licensing and surveying process that HSS conducts, as a result of the Support Coordinator's monthly contacts with participants and their legal representative(s), or as a result of receipt of a critical incident report or complaint.

OCDD does not support the use of restraint (which will be referred to as protective supports and procedures) as a true behavioral intervention with application contingent on exhibition of a specific problem behavior on a routine basis. Rather, it is only to be used in situations where there is immediate, imminent risk of harm to self or others if physical intervention does not occur. Protective supports and procedures are incorporate in the Plan of Care if use is anticipated based on the participant's behavioral trends and patterns. Behavioral challenges are addressed in an ongoing plan that utilize other appropriate and less restrictive techniques to prevent the problems, de-escalate them when they occur, and teach appropriate options/coping skills/replacement behaviors.

The direct service provider is responsible for reviewing incidents and trends while OCDD is responsible for reviewing direct service provider practices and use of protective supports and procedures. Incidents reaching a specified threshold will be reviewed by the OCDD Clinical Review Committee.

Almost any other technique is considered less restrictive than restraint use besides medication for the purposes of sedating the participant or use of aversive conditioning techniques which OCDD does not allow. Plans are written by private psychological service providers and as a result, the techniques will vary, but may include:
Preventive strategy examples:

1. Identification of triggers for the challenging behavior and avoidance of triggers (i.e., noise may be a trigger so efforts are made to avoid loud/crowded spaces); and
2. Identification of things the participant enjoys and times/activities during which the challenging behavior is least likely to occur and providing increased opportunities for accessing meaningful/enjoyable things (i.e., finding someone a job that they enjoy; spending more time with family if this is important, etc).

Teaching examples:

1. Teaching the participant problem solving, anger management, or relaxation skills to avoid escalation of the challenging behavior and then teaching staff to recognize the early signs of agitation and how to prompt use of the new coping skills; and
2. Reinforcing exhibition of appropriate behavior (identified in the plan) and not reinforcing the challenging behavior so it is more likely that appropriate behavior alternatives will be chosen Intervention examples:

1. Blocking the participant from reaching an object he/she may throw or a person he/she may hit but not actually holding or restraining the participant; and
2. Removing objects that may be used aggressively.

Again, it should be noted that these are only examples in each category of possible strategies. There are many other alternatives that may be used. Each plan is tailored to meet the participant's needs and is developed by different professionals. The use of restraints requires prior permission. Informed consent is obtained from the participant or his/her legal guardian relevant to the participant's consent for implementation of the plan. At a minimum, informed consent includes the essential components necessary for understanding the potential risks and benefits of the plan. Also, the participant or legal guardian shall be informed of the right to withhold or withdraw consent at any time. If a restraint is unplanned, as in emergency situations, prior permission is not obtained. However, unplanned restraints are based on the fact that the restraint is a response

to an emergent situation in which imminent risk of harm exists to person and/or others.
Strategies considered prior to restraint use include Positive Support Procedures (based on the individual support need), Desensitization, assessment by allied health professionals for alternate communication strategies, and identification of possible medical antecedents, etc.

When restraint is used for behavior support procedures, a licensed psychologist authorizes the use. When restraints are used for medical protective supports and procedures (as those applied as a health-related protection) a licensed physician, licensed dentist, or licensed podiatrist, authorizes the use.

The following practices are employed to ensure the health and safety of individuals when restraints are used:

• Staff training and competence: Staff must be competent in the use of restraint methods to avoid/prevent use of restraints and methods for implementing emergency restraints when necessary as a last resort. Required competencies include demonstration of knowledge of OCDD's philosophy and policy re: use of restraints and knowledge concerning the conditions necessary for implementation of emergency restraints; competency in use of procedures taught in standard state approved programs for managing aggressive behaviors or an alternate crisis intervention system that does not use prone personal restraints; demonstration of competency in outlined support plan strategies relative to avoiding/preventing use of restraints and any methods for guiding the person more effectively, as well as the use of specific types of emergency restraints before applying them (inclusive of application, release, documentation, monitoring, and other information relative to safety of administering these procedures); staff responsible for visually and continually monitoring the person in behavioral restraints shall demonstrate competency in knowledge/implementation of agency protective support policies, application of protective supports, recognizing signs of distress, recognizing when to contact physician or emergency medical service so as to evaluate/treat the person's physical status, and documentation; demonstration of knowledge/competency in, and procedures for accessing emergency medical services rapidly; competency/training in all aspects of applying medical restraints as prescribed by the person's physician (inclusive of training on strategies for reducing time in which medical restraints are required as outlined in support plan and documentation of training on essential steps for applying mechanical restraints and for implementing support plan strategies).

• Implementation: Each agency must have a policy that defines minimum components include defining limitations on use of restraints within the agency in a manner that is consistent with OCDD policy/philosophy on protective supports; a system to identify who is qualified to implement restraints within the agency (with agency maintaining tracking of which staff are trained and when annual re-training is to occur); each agency must have a system for tracking the use of emergency restraints and mechanical restraints, if used; and each agency where emergency restraints are implemented must have safety procedures in place to protect the participant and staff (inclusive of provision of back up staff in the event of an emergency; procedures to check health of the person prior to, during and following implementation of emergent restraints, as well as safety actions to maximize safety of participant/others; procedures for addressing incidents that led to the use of emergency restraints (including development of a Positive Behavior Support Plan that include strategies to prevent/avoid future incidents and is integrated into the support plan); and procures to review incidents within 24 hours so as to prevent, to act quickly, or avoid future incidents).

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:

• The Health Standards Section of Bureau of Health Services Financing (BHSF), the Medicaid Agency, is responsible for monitoring that client rights are observed and that there are no negative outcomes related to the use of physical or chemical restraints.

• Oversight is conducted through ongoing monitoring of Critical Incident/Incident Reports via the Online Tracking Incident System (OTIS) and Health Standards Section will investigate incidents involving complaints involving immediate jeopardy, serious injuries, and other serious critical incidents.

• The OCDD Regional Waiver Supports and Services Office or Human Services Authority or District staff may refer reports of use of restraint to the State Office Review Committee for guidance and recommendations.

• Any participant who has had a protective hold used is placed on the high risk monitoring list.

• Unauthorized, over use or inappropriate use of restraints is detected through the annual monitoring HSS conducts or as a result of support coordinator's monthly contacts with participants and their legal representative(s), or as a result of receipt of a Critical Incident report.

• The OCDD Critical Incident Program Manager and HSS ensure that all applicable state requirements have been followed regarding restraint as part of the Critical Incident report review process.

• OCDD has developed the Online Tracking Incident System (OTIS) to identify trends and patterns and support improvement strategies regarding Critical Incidents. This system allows the Health Standards Section of BHSF and OCDD to work together to collect and compile data and use it to prevent reoccurrence of incidents.

The operating agency provides the Bureau of Health Services Financing with aggregate data and reports which are inclusive of any reported restraint use, etc. Aggregate data is provided to the Medicaid Agency on a quarterly basis and every fiscal year.

ppendix 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 oversigh is conducted and its frequency:

The State prohibits the use of restrictive interventions. The state strategies for detecting unauthorized use of restraints is through review of critical incident reports, complaints, support coordinator quarterly contacts with participants and families.

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, restric 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.

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:

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:

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)

his Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements here a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when aiver 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)*

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 Support Coordinator is responsible for including medications, entity responsible for medication administration, and oversight into the participant's Plan of Care.
If the participant's direct service worker(s) is listed as being the responsible party for medication administration, authority is documented through the State Certified Medication Attendant Program or through physician delegation.

The Support Coordination agencies contracted by the state who serve the participants are required to have a Registered Nurse Consultant on their staff. These RN Consultants are responsible for ongoing monitoring of participant medication regimens.

The Support Coordination agency's RN Consultant reviews all medication regimens initially and annually at the time of the Plan of Care for all participants who are served in living arrangements where a provider has round the clock responsibility for the health and welfare of residents, and enters the date of review into CMIS. After the review is completed, the RN notifies the Support Coordinator if the participant has:

a. an especially complex medication regimen or:
b. is prescribed behavior modifying medications as part of their treatment program.

The RN enters the date of the medication review into CMIS.

When a Support Coordinator is notified of the above, the Support Coordinator will contact the RN Consultant after each quarterly face-to-face participant visit in order to give the RN Consultant an update and answer any questions the RN may have relevant to the participant's regimen. The Support Coordinator enters the date of contact with the RN into CMIS. At any time that a Support Coordinator has non-emergency health -related concerns they notify the RN Consultant.

During quarterly face-to-face contact with the participant the Support Coordinator obtains an update on medical and health related information, including physician visits, treatments, hospitalizations, medication updates and ensures that physician delegation, if applicable, is current.

If either the RN consultant or the Support Coordinator detects any potential harmful practices, the RN Consultant makes a face-to-face visit with the participant and when necessary follows up with the participant's medical practitioner. If a medication management issue also meets the OCDD criteria for a critical incident it is reported according to OCDD Critical Incident Policy.

The OCDD Regional Waiver Office or Human Service Authority or District approves all initial and annual Plans of Care to ensure that:

- Information is included regarding whether or not the participant self-administers medication;
- If the participant does not self-administer, there is a current signed and dated Physician Delegation Form; and
- Medications listed have been properly recorded and match those listed on the Form 90-L.

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.

OCDD is responsible for the oversight of medication management and follow up.

OCDD and OCDD staff review and approve Plans of Care that include the participant's medication and medication administration. Health Standards is responsible for surveys that monitor waiver participants which includes assessing medication administration for those included in the monitoring sample.

The Health Standards Section conducts a State Survey and Complaint investigations for ROW Waiver Home and Community Based Service Providers serving waiver participants in a sample review. This survey includes an assessment of services provided and their outcomes. The sample selection will be large enough that it will meet the requirements for a confidence level of 95% +/- 5%. Types of services reviewed include medications and treatments ordered by physicians. HSS ensures that corrective action occurs if findings warrant. Follow up will be conducted in those cases. HSS will share its findings with OCDD.

In accordance with OCDD policy, critical incidents regarding medication errors must be reported to the OCDD Regional Waiver Office or Human Service Authority or District. They are responsible for investigating critical incidents regarding medication management and following up with the Support Coordinator and direct service provider to ensure that any unsafe practices are remedied. OCDD will share discovery of possible deficient provider practices with HSS and WCS. Reports will be sent quarterly.

The OCDD State Office Quality Enhancement Section has the responsibility to:

- Analyze and trend data received from the HSS and medication critical incidents in order to identify potentially harmful practices and implement training, technical assistance, and policy and procedural changes to improve quality.
- Develop reports for OCDD staff, committees, and external stakeholders, as appropriate.

The Online Tracking Information System (OTIS), an on-line, web-based reporting system for all critical incident reporting, including major medication incidents and staff , pharmacy, family, or participant medication errors expands and clarifies reporting categories and definitions for medication critical incidents.

OTIS allows the Support Coordination Agency and the OCDD staff to directly input critical incident reports, follow-up information

and resolution into the system and generate individual and aggregate reports. The system also allows real-time access and viewing of information for OCDD, HSS-BHSF, Adult Protective Services and Support Coordination Agencies.

Medication management monitoring is included in the critical incident data reports submitted to the SMA quarterly. WCS reviews critical incident reports from the operating agency on a quarterly basis to determine if they were resolved appropriately and timely and to determine trends and patterns that indicate further action by WCS. WCS monitors the data reports to see if remediation activities were effective in improving data results from the previous time period. If remediation activities were not effective, the SMA will meet with the operating agency to address any changes needed to remediation strategies in order to improve results. The SMA will continue to follow up with the operating agency to evaluate remediation for effectiveness. WCS also conducts look-behind reviews on data submitted by the operating agency.

WCS reviews reports from the operating agency on a quarterly basis to determine if they were resolved appropriately and timely and to determine if there are any trends and patterns that indicate further action is needed. WCS also monitors the data reports to see if remediation activities implemented in the previous quarter were effective in improving data results for the current period. If remediation activities were not effective, the SMA will meet with the operating agency to address any changes needed to remediation strategies in order to improve results. The SMA will continue to follow up with the operating agency to evaluate remediation for effectiveness.

WCS also conducts a look-behind review of critical incidents to ensure remediation activities occurred correctly and timely; if necessary steps were taken in response to reported incidents; and if appropriate referrals to HSS and protective services/law enforcement were made.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Unlicensed direct care staff who perform administration of medications or procedures may currently do so under physician delegation. The physician signs a written document which indicates the participant's procedures, medications, dosages, site of administration and instructions. This document verifies that the delegating physician has provided specific training and instructions to the direct care staff concerning the listed medications and/or procedures, and verifies that they are acting under the physician's authority. Each provider agency's administration has the responsibility for conducting on-site visits and assessments of all employees delegated by the personal care physician to give medications. They must also provide oversight when a person self-medicates.

In addition, the DHH-OCDD administers the Certified Medication Attendant Program which provides for the training and certification of unlicensed direct care staff through certified nurse instructors who are also trained by DHH-OCDD. These persons are trained to administer medications to persons with developmental disabilities. The state statute provides for the qualifications of the drug administration course and course applicants/participants and specifies authorized and prohibited functions for such certified provider personnel. This Program is available to both waiver and institutional providers of developmental disabilities services.
Waiver provider personnel are mandated to have a minimum of 16 hours of training prior to working with a participant and up to 16 hours per year of continued education per licensing regulations including physician delegation training. HCBS 16 hours annually,and CMGT 40 hrs annually.

The department is in the process of promulgating a final rule which will amend the training requirements for direct care staff to provide for training in medication administration and non-complex tasks In accordance with Act 299 of the 2011 legislative session. The training is designed to assure safe administration of medications to waiver participants who require medication administration and participants who cannot self- administer or exercise oversight. It will be a 16 hour course with the training being provided by a registered nurse or by a licensed practical nurse with oversight by the RN. The licensed nurses will be employed or contracted by the licensed provider. Once fully implemented, the practice of using physician delegation as a mechanism for clients to receive medications, will be phased out. The Louisiana State Board of Nursing worked closely with departmental staff in developing the rule.

iii. Medication Error Reporting. *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

Medication errors are reported by waiver providers through the OTIS Critical Incident Reporting system, which is accessed by the Health Standards Section and OCDD with the latter conducting follow-up for corrective actions via its OCDD Regional Waiver Supports and Services Offices or Human Services Authorities or Districts and contracted Support Coordinators.

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

The administration of medication:
- In an incorrect form;
- Administered to wrong person;
- Administered but not as prescribed (dose & route);
- Ordered to the wrong person; or
- The failure to administer a prescribed medication.

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

Medication administration incident reporting:

- Major medication incident - the administration of medication in an incorrect form, not as prescribed or ordered to the wrong person or the failure to administer a prescribed medication, which requires or results in medical attention by a physician, nurse, dentist or any licensed health care provider.

- Staff error: The staff failure to administer or administered the wrong medication or dosage to a person. Staff failure to fill a new prescription order within 24 hours or a medication refill prior to the next ordered dosage.

- Pharmacy error: The pharmacy incorrectly dispenses the meds etc.

- Participant error: The participant unintentionally fails to take medication as prescribed

- Medication Non-Adherence: The participant refuses medication for three consecutive days

- Family error: A family member intentionally or unintentionally fails to administer a prescribed medication refill to the participant prior to the next ordered dosage

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:

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iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

HSS is the State agency responsible for monitoring waiver providers which includes the administration of medications for those clients included in the monitoring sample and to assure that there is no negative outcomes.

HSS identifies problems in provider performance through their licensing and survey reviews of all Medicaid enrolled direct service providers. This includes a review of medication administration records, policy, and reporting policy.

The Online Tracking Information System (OTIS), an on-line, web-based reporting system for all critical incident reporting, including major medication incidents and staff or pharmacy medication errors. The System expands and clarifies reporting categories and definitions for medication critical incidents. OTIS allows real-time access to information for OCDD, BHSF- Waiver Assistance and Compliance and Health Standards Sections, Adult Protective Services and Support Coordination Agencies.

OCDD will share discovery of possible deficient provider practices with HSS. The OCDD State Office Quality Enhancement Section will aggregate, track and trend data from the HSS and medication critical incidents and disseminate reports to OCDD staff and committees, as appropriate. These reports will be used to identify potentially harmful practices and implement training, technical assistance, and policy/procedural changes to improve quality statewide. The OCDD Quality Enhancement Section reports findings to the Medicaid agency (BHSF).

OCDD's discovery of medication errors and related concerns may surface at any time and result from OCDD Regional Waiver Supports and Services Offices or Human Services Authorities or Districts' ongoing, real-time reviews of OTIS critical incident reports (which include medication errors), from support coordinators quarterly on-site reviews and monthly contacts with participants and from direct complaints from participants, families or other stakeholders which may be phoned into OCDD's OCDD

Regional Waiver Supports and Services Offices or Human Services Authorities or Districts or State Office. As these medication-related concerns surface, the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District staff follow up to assure that appropriate corrective actions have been implemented by waiver providers. OCDD Regional Waiver Supports and Services Office or Human Services Authority or District staff's follow up to critical incidents involving medication is entered into the OTIS data base which is automatically accessible to the the State Medicaid Agency and Health Standards Section.

When discovery of medication-related critical incidents involve abuse/neglect, immediate jeopardy to participants, fraudulent claims or other serious licensing deficiencies, they are immediately reported to the respective DHH Bureau, Section or Program Office with legal authority to investigate, sanction, recoup or take other actions to protect waiver participants (i.e., OAAS/Adult Protective Services; Health Standards Section; BHSF/Program Integrity Section).

The OCDD Quality Enhancement Section's aggregate data from the OTIS database on trends and patterns of critical incidents involving medication errors will be reviewed quarterly by the OCDD Performance Review Committee and summary reports forwarded the BHSF/Waiver Assistance and Compliance Section.

WCS reviews critical incident reports from the operating agency on a quarterly basis to determine if they were resolved appropriately and timely and to determine trends and patterns that indicate further action by WCS. WCS also monitors the data reports to see if remediation activities were effective in improving data results from the previous time period. If remediation activities were not effective, the SMA will meet with the operating agency to address any changes needed to remediation strategies in order to improve results. The SMA will continue to follow up with the operating agency to evaluate remediation for effectiveness.

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. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G 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 i analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.a.i.a.1. The number of reported critical incidents and rate per thousand participants in the ROW. Percentage = Number of critical incidents times one thousand / Total number of ROW participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Online Tracking Incident System (OTIS)

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.i.a.2. Number and percentage of critical incidents reported alleging abuse, neglect, exploitation, or extortion that were substantiated by Protective Services/law enforcement. Percentage = Number of substantiated allegations of abuse, neglect, exploitation or extortion / Total number of reported allegations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Online Tracking Incident System (OTIS)

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.i.a.3. Number and percentage of critical incidents that are reported within the timelines specified in the policy. Percentage = Number of critical incidents reported within the required timelines / Total number of critical incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Online Tracking Incident System (OTIS)

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

Performance Measure:
G.a.i.a.4. Number and percentage of critical incidents where all necessary follow-up was completed and appropriate actions were taken as measured by closure of the critical incident. Percentage = Number of critical incidents that were closed in the system appropriately / Total number of critical incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Online Tracking Incident System (OTIS)

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):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:

	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:
G.a.i.a.5. Number and percentage of abuse/immediate jeopardy complaint investigations conducted within 2 working days of receipt by Health Standards. Percentage = Number of abuse/immediate jeopardy complaints conducted within 2 working days of receipt by Health Standards / Total number of complaints received.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ASPEN Health Standards Immediate Jeopardy Log

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):*
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify:	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other

		Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

Performance Measure:
G.a.i.a.6. Number and percentage of participants who have an emergency evacuation plan. Percentage = Number of participants who have an emergency evacuation plan / Total number of participants reviewed in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC/POC Database

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 95% +/- 5%
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other	

Specify:

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.i.a.7. Number and percentage of participants who have an individualized back-up plan. Percentage = Number of participants who have an individualized back-up plan / Total number of participants reviewed in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC/POC Database

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.i.a.8. Number of reported critical incidents for medication errors and rate per thousand participants in the ROW. Rate = Number of critical incidents reported for medication errors times one thousand / Total number of ROW participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Online Tracking Incident System (OTIS)

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:
G.a.i.a.9. Number of reported critical incidents for deaths and rate per thousand participants in the ROW. Rate = Number of critical incidents reported for death times one thousand / Total number of ROW participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Online Tracking Incident System (OTIS)

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):*
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify:	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
State Medicaid Agency	Weekly

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:
G.a.i.a.10. Number of reported critical incidents for use of restraints and rate per thousand participants in the ROW. Rate = Number of critical incidents reported for use of restraints times one thousand / Total number of ROW participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Online Tracking Incident System (OTIS)

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):*
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify:	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
State Medicaid Agency	Weekly
Operating Agency	Monthly

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

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 i analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

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 i analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

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 i 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. In addition, provide information on the methods used by the State to document these items.

Remediation for all performance indicators except for G.a.i.a.5 is tracked within the Online tracking Incident System (OTIS) and LOC/POC databases. OCDD runs quarterly reports for critical incidents. OCDD runs complaints and LOC/POC reports annually. Performance indicators G.a.i.a.3, G.a.i.a.4,G.a.i.a.5, G.a.i.a.6, and G.a.i.a.7 can be remediated. However, performance indicators G.a.i.a.1, G.a.i.a.2, G.a.i.a.8, G.a.i.a.9 and G.a.i.a.10 are to track trends in the data for quality improvment and are not subject to remediation. These indicators are to identify trends and patterns in order to address systemic issues with quality improvement initiatives. for example, throught our mortality review process we identified training needed for direct support staff on signs and symptoms of illness. Training modules were developed and provider agencies were required to attend the training. The critical incident data is also reviewed at the individual level to assure that all necessary action are taken to reduce the likelihood for that participant to experience similar critical inccidents in the future. OCDD Regional Office or Hman Services Authority or District staffreviews every critical incidnet and work with the support coordinator and provider to assure necessary follow-upis done. The OCDD Regional Office or Human Services Authority or District staff will not close the case until the follow-up is done. As necssary, provders are requried to develop corrective action plans. Not all critrical incidents are avoidable and not all reauire a corrective action plan. For example, deaths occur that are not preventable. But we review all deaths to identify those for which provider corrective actions are needed and to identify trends and patterns that may require quality improvement initiative such as the training on signs and symptoms of illness for provider agencies.

WCS reviews critical incident reports from the operating agency on a quarterly basis to determine if they were resolved appropriately and timely and to determine trends and patterns that indicate further action by WCS. WCS also monitors the data reports to see if remediation activities were effective in improving data results from the previous time period. If remediation activities were not effective, the SMA will meet with the operating agency to address any changes needed to remediation activities in order to improve results. The SMA will continue to follow up with the operating agency to evaluate remediation for effectiveness. WCS also conducts a look-behind review of all critical incidents to ensure remediation occured correctly and timely; if necessary steps were taken in response to reported incidents; and if appropriate referrals to HSS and protective services/law enforcement were made.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By

completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

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

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, OCDD Regional Waiver Supports and Services Office or Human Services Authority or District, 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 DHH 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.

OCDD Regional Waiver Supports and Services Office or Human Services Authority or District Processes:

• OCDD Regional Waiver Supports and Services Office or Human Services Authority or District 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 OCDD Regional Waiver Supports and Services Office or Human Services Authority or District 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 Regional Waiver Supports and Services Office or Human Services Authority or District, 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, Human Services Authority or District 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 Regional Supports and Services Waiver Office or Human Services Authority or District 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.

• Regional Office 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, nor the waiver because they serve multiple waiver and Medicaid targeted populations.

The Quality Improvement System (QIS) for the Residential Options 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 ROW, these waivers include:
• Adult Day Health Care Waiver
• New Opportunities Waiver
• Children's Choice 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 Waiver Compliance Section of the state Medicaid agency (WCS), 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, and WCS & 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 & 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*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

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 WCS and the Quality Waiver Review Team. After each quarter of implementation, up to one year post-implementation, WCS 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 reviews of the OCDD 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

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).

DHH 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, DHH 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 ROW 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 recipients 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 specifie 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-assuranc 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 i 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 waiver services provided to participants who were enrolled in the waiver on the date the service was reported as delivered. Percentage = Number of waiver services provided to participants who were enrolled in the waiver on the date the service was reported as delivered / Total number of waiver services reported as delivered.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid data contractor system

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Medicaid data contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (*check each that applies):*	**Frequency of data aggregation and analysis** (*check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

I.a.2. Number and percentage of waiver claims submitted which did not exceed the approved rate. Percentage = Number of submitted waiver claims which did not exceed the approved rate / 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (*check each that applies):*	**Frequency of data aggregation and analysis** (*check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
I.a.3. Number and percentage of reports in which cost neutrality was maintained. Percentage = Number of reports in which cost neutrality was maintained / Total number of reports reviewed.

Other
If 'Other' is selected, specify:
372 report

Responsible Party for data collection/generation(*check each that applies):*	**Frequency of data collection/generation**(*check each that applies):*	**Sampling Approach**(*check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify: Fiscal intermediary	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (*check each that applies):*	**Frequency of data aggregation and analysis** (*check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify: Fiscal intermediary	**Annually**
	Continuously and Ongoing
	Other Specify:

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 i

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. In addition, provide information on the methods used by the State to document these items.

BHSF reviews reports on aberrant billing practices and provider enrollment on a monthly basis to identify areas of non-compliance, determine if the results indicate there are on-going or systematic problems, and determine remediation actions needed. Remediation action is taken by the SMA if systemic problems are identifed. The entities responsible for remediation actions include the data contractor and the contracted fiscal intermediary. The SMA meets with the contractor to determine how the problem occurred and to implement steps to correct the problem. These actions are tracked via the Louisiana Medicaid Management Information System. The SMA may impose monetary penalties depending on the type of problem identified.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

Rates for the ROW are initiated by the Office of Citizens with Developmental Disabilities (OCDD) with input from a group of interested parties, including but not limited to providers and or provider groups, program participants, advocates, and Medicaid representatives. OCDD's process for developing rates for ROW waiver services is based on rates for similar services in other waivers with review by Medicaid personnel for appropriateness. The overall budget cap for each person in the ROW is established based on his overall Inventory for Client and Agency Planning (ICAP) score. This allows flexibility for each individual's plan to include an array of services

needed within the overall budget cap. If the Medicaid personnel concur that the rates are feasible, can be utilized within the individual's overall budget and represent cost neutrality, then they are submitted to the Medicaid Director as part of the waiver application for final review and approval. Subsequently the reimbursement methodology is included in the Medicaid rulemaking process. This rulemaking process includes further opportunity for public comment.

As rates are proposed for each service in the ROW, OCDD presents the rates and service definitions to the Medicaid liaison and other Medicaid representatives as part of the waiver application review.

1. OCDD recommends rates to Medicaid based on the following hierarchy of factors:
   a) If there is a comparable service already existing in another OCDD program (i.e. waiver) that rate is mirrored.
   b) If there is no existing comparable service, OCDD explores the rates that are compatible with other similar services which are provided by Medicaid (i.e. nursing services).
   c) If no comparable Medicaid services and rates exists, OCDD explores services in the general community that are comparable and attempts to match the prevailing competitive rates.

2. Based on the choices available in #1 above, OCDD recommends the service rate to Medicaid where it is reviewed and a determination made of the fiscal impact and budget availability for funding with a final determination made on the service rate.

The ROW budgets follow the ICAP rates which were rebased and are developed within Medicaid. Therefore, the Medicaid Director has not only oversight, but also direct control over the rate determination process.

No rate can be implemented without the approval of the Medicaid Agency (BHSF).

Rates for each service are based on the following:

*Community Living Supports (CLS) and Out-of-Home Respite rates were negotiated based upon the estimated provider cost of rendering the service and similar services as provided in other waivers. The cost of transportation is built into the CLS rate.

When CLS is 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 CLS provider for exercising oversight, monitoring, and facilitating an agreement between the CLS provider and CLS worker. This cost component is absent when this service is self-directed. Otherwise, these rates for self-direction are initiated by OCDD and submitted to Medicaid in the same manner and in accordance with the same processes, including opportunity for public comment, as other service rates.

In addition, Factor D charts in Appendix J of the ROW Application reflect a weighted average cost per unit for each year which includes the average of shared rates for Community Living Supports.

* Professional Services and Nursing rates were based upon several factors: the cost to the provider to provide the service, the cost to secure the service out in the community, the cost of similar services in current OCDD contracts, and state payment rates for full time employees.

* Services and rates for dental services were taken from an existing packaged plan of dental services as offered to Medicaid recipients under the EPSDT, Pregnant Woman and Adult Denture programs.

* Louisiana considered the following factors in establishing its ROW day habilitation, prevocational services and supported employment rates as part of its negotiations with providers and with input from other stakeholders: (1) allowances for direct support worker and other staff wages; (2) the provider's overhead costs; (3) transportation costs (per mile) from the vocational agency to all work sites; and (4) a profit margin for the provider.

The rate allowed by the State for supported employment, day habilitation, and pre-vocational services take the following factors into consideration when determining the rate: wages (55%); administrative (10%); overhead, which includes costs for building, equipment, supplies, insurance, and gas (30%); and profit margin (5%). The value of the profit margin is consistent with and comparable to that of similar services provided in the community. The State's estimated profit margin is at 5% of the rate. The value of the administrative and overhead costs are consistent with and comparable to that of similar services provided in the community.

* Transportation rates for Community Access were based on transportation rates payable in other waivers.
* Personal Emergency Response System rates are based on the actual cost of providing the service.

* One Time Transitional Services are paid at the cost of the provision of services with an annual cap. This cap was set based on the historical cost allowed for providing the service in other waivers.

* Environmental Accessibilities Adaptations and Assistive Technology/ Specialized Medical Equipment and Supplies costs are based on historical expenditures for these services in waivers serving similar populations.

* The Companion Care rate is paid to the provider at a daily rate. This rate includes the cost of payment to the Companion worker for services delivered plus an additional cost component payable to the Companion Care provider for oversight, monitoring, and facilitating an agreement between the provider and Companion worker. The rate was based on the limited hourly rate established by the

anticipated users of the service and their level of need, plus an estimate of the amount of actual direct care service hours to be provided each day.

* The rates for the Host Home service are graduated according to level of need. The Host Home rates were determined by the increased complexity of the individuals' needs and the associated responsibilities of the Host Home dictated by the score on the ICAP.

* Shared Living and Shared Living-Conversion rates are based on several factors: employee costs, including wages and benefits; indirect costs such as transportation and administration; and staffing requirements and occupancy. All rates are graduated according to the intensity of the need of the individual. The Shared Living rates were determined by the staffing level/ratio required for the increasing acuity level of the individuals being served. The greater the acuity level, the greater the amount of staffing needed. The acuity level was determined by each individual's score on the ICAP.

The ROW per diem rates and annual budget amounts are calculated based on State Fiscal Year ICAP rates used to determine ICF/DD funding under four acuity levels of recipient needs (intermittent, limited, extensive & pervasive), minus applicable adjustments (provider fees and patient liability). These ROW rates per acuity level are based on each participant's ICAP score and set the overall budget amount (or cap) a ROW participant must fall within when choosing an array of services and tailoring a support plan to meet individual needs. Although the budget amounts set overall caps on expenditures per acuity level, there is much flexibility in choosing individual services which have minimal to no caps placed upon them.

* Support Coordination Services Rate is a conversion of the former contracted monthly service rate paid to support coordination providers into a rate based on 15 minute increments. The conversion utilized a nationally recognized rate-setting consultant who surveyed providers relative to their time, activities performed, staffing requirements, general administrative and indirect expenses to develop a model for achieving the 15 minute increment rate.

• 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 bachelors degree and are qualified to provide two levels of supervisions. An agency trainer or nurse consultant who meets the requirements a support coordinator can also be reimbursed a per quarter rate for services provided. Administrative support, travel and office operating expenses are included in the 15 minute billing rate.

All proposed rates are then factored into a cost projection and model to produce and 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 coordinators and agencies, as well as through publication in the Louisiana Register, the official journal for the state of Louisiana. Participants may also receive information on service rates by contacting their OCDD Regional Waiver Services and Supports Office or Human Services Authority or District.

OCDD solicited public input from recipients, providers, and advocacy organizations to determine rate, structure methodology, etc. This is accomplished through meetings with these entities around the state.

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 Medicaid data contractor for post authorization. After services are authorized, providers bill directly to the Medicaid fiscal intermediary for payment.

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 tha 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 fo 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 expenditure 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 Health Services Financing (BHSF) utilizes a prior authorization and post authorization system maintained by a contracted entity to ensure that services provided to waiver participants are provided and paid for within the scope, duration, and frequency as specified in the approved plan of care. Medicaid eligibility for services is also checked and reviewed by the prior authorization entity.

Services are prior authorized according to the Plan of Care in quarterly increments and post authorized for payment after services have been rendered.

1. The prescribed services identified in the Plan of Care are entered in quarterly increments into the prior authorization system.

2. Upon the provision of services to the participant, the provider submits the service utilization data to the post authorization entity.

3. The post authorization entity checks the service utilization record against the participant's approved Plan of Care which identifies the prior authorized services.

4. Post authorization for payment is released to the Fiscal Intermediary when services are properly rendered to participants per the approved Plan of Care and prior authorization.

5. The provider then submits claims for approved services to the Fiscal Intermediary for adjudication and payment.

6. Services provided to participants that are not listed on the prior authorization system are rejected and ineligible for payment until all discrepancies are resolved.

In Program Integrity's SURS unit, cases are opened once a month; however, a case may be opened sooner depending on the priority or type of case. Some production runs are performed monthly and some are performed quarterly. Data mining is performed on a weekly basis, and projects are opened throughout the year. Complaints and internal referrals are received daily and are prioritized. The scope of a case may vary from being recipient-focused to a general review of the provider's billing, or it may be in-between as in limited to specific billing codes depending on what the evidence reveals.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

◉ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

○ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

A fiscal/employer agent will provide fiscal management services to Self-Direction participants, as an administrative activity. Payments will be made to employees for direct services to the waiver self-direction participants related to the service Community Living Supports. 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 employee, 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.

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.

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:

The Louisiana State Legislature has re-named the OCDD Developmental Centers as "Regional Service Centers" in order to capture their current mission of providing a full range of community-based services. The OCDD Regional Service Centers will provide services to ROW waiver participants and will be paid for those services. Those ROW services will include shared living, supported employment, prevocational services, day habilitation, and professional services. These waiver services delivered by the Regional Service Centers are not located in institutional-based settings.

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:

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.

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). Th §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 no -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 -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:

Fixed rates for these services do not include any margin for room and board related expenses. The provider contracts specify that room and board expenses must be covered from sources other than Medicaid, such as consumer fees, donations, fund raising, or state funded programs. Providers of waiver services are contractually prohibited from billing for room and board expenses through Medicaid.

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.

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.

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.

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-sharin 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:

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	26877.60	17693.00	44570.60	85268.00	5111.00	90379.00	45808.40
2	26578.61	17693.00	44271.61	85268.00	5111.00	90379.00	46107.39
3	26800.44	17693.00	44493.44	85268.00	5111.00	90379.00	45885.56
4	27671.49	17693.00	45364.49	85268.00	5111.00	90379.00	45014.51
5	27699.27	17693.00	45392.27	85268.00	5111.00	90379.00	44986.73

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	225	225
Year 2	325	325
Year 3	425	425
Year 4	525	525
Year 5	625	625

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.

In developing estimates for the ROW, information from an existing CMS approved waiver was used as much as possible. The estimate for the average length of stay given for the ROW is based on La.'s data from the New Opportunities Waiver which serves a similar population.

Historical ALOS data from the ROW was also considered for estimates.

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 the projected participants, service utilization, and proposed rates for each service under the waiver. Some of the utilization and costs per service assumptions were based on similar services in other waivers serving the population of persons with developmental disabilities. Services such as environmental modifications, specialized medical equipment, and other services similar to other waivers were considered in the assumption of utilization.

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 assumptions based on best professional judgment.

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 participants to get an estimated average cost. A utilization inflation factor is thereby applied to each subsequent year based on program history and assumptions based on best professional judgment.

The State used data from existing waiver populations, with the assumption that these populations are comparable to the population served by ROW. Specifically, the population for this waiver will be existing ICF-DD participants, present and possible, as well as individuals on the DD Request for Services Registry. Therefore, the State's dual eligibles will essentially be nearly the same or a similar population as identified in the Supports Waiver and NOW.

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

1. Identified all ROW participants 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 participant was derived; and
4. Deducted this amount from the average acute care cost per waiver participant.

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 private intermediate care facilities for individuals with developmental disabilities (ICF/DD). This dollar amount is totaled and then divided by the number of waiver participants 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:

is an estimate based on the actual Medicaid expenditures for all other Medicaid services provided to citizens residing in intermediate care facilities for individuals with developmental disabilities (ICF/DD). This dollar amount is totaled and then divided by the number of waiver participants to get an estimated average cost. A utilization inflation factor is thereby applied to each subsequent year based on program history and other factors. These "other factors" refer to assumptions based on best professional judgement.

To exclude Medicare Part D Pharmacy cost from our cost effectiveness calculations we:
1. Identified all ICF/DD individuals 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; and
4. Deducted this amount from the average acute care cost per ICF/DD individual.

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 bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Day Habilitation	
Prevocational Services	
Respite Services - Out of Home	
Shared Living Services	
Support Coordination	
Supported Employment	
Assistive Technology/Specialized Medical Equipment and Supplies	
Dental	
Community Living Supports	
Companion Care	
Environmental Accessibility Adaptations	
Host Home	
Housing Stabilization Service	
Housing Stabilization Transition Service	
Nursing	
One-Time Transitional Services	
Personal Emergency Response System	
Professional Services	
Transportation - Community Access	

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
ay Habilitation Total:						165390.00
Day Habilitation	2.5 hours	30	298.00	18.50	165390.00	
				GRAND TOTAL:		6047459.69
				Total Estimated Unduplicated Participants:		225
				Factor D (Divide total by number of participants):		26877.60
				Average Length of Stay on the Waiver:		356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services Total:						**119137.50**
Prevocational Services	2.5 hours	15	353.00	22.50	**119137.50**	
Respite Services - Out of Home Total:						**370.56**
Respite Services - Out of Home	15 minutes	4	24.00	3.86	**370.56**	
Shared Living Services Total:						**1784250.00**
Shared Living Services	Per Diem	100	305.00	58.50	**1784250.00**	
Support Coordination Total:						**431055.00**
Support Coordination	15 minutes	225	103.00	18.60	**431055.00**	
Supported Employment Total:						**8268.00**
Supported Employment	15 minutes	15	212.00	2.60	**8268.00**	
Assistive Technology/Specialized Medical Equipment and Supplies Total:						**924.00**
Assistive Technology/Specialized Medical Equipment and Supplies	Per Item	4	1.00	231.00	**924.00**	
Dental Total:						**706.44**
Dental	Per Procedure	4	3.00	58.87	**706.44**	
Community Living Supports Total:						**3164767.68**
Community Living Supports	15 minutes	48	17081.00	3.86	**3164767.68**	
Companion Care Total:						**119720.00**
Companion Care	Per Diem	8	365.00	41.00	**119720.00**	
Environmental Accessibility Adaptations Total:						**49752.60**
Environmental Accessibility Adaptations	Per Item	4	3.00	4146.05	**49752.60**	
Host Home Total:						**3791.55**
Host Home	Per Diem	69	1.00	54.95	**3791.55**	
Housing Stabilization Service Total:						**0.00**
Housing Stabilization Service	15 minutes	0	0.00	15.11	**0.00**	
Housing Stabilization Transition Service Total:						**0.00**
Housing Stabilization Transition Service	15 minutes	0	0.00	15.11	**0.00**	
Nursing Total:						**163283.64**
Nursing	15 minutes	12	1703.00	7.99	**163283.64**	

GRAND TOTAL:	**6047459.69**
Total Estimated Unduplicated Participants:	**225**
Factor D (Divide total by number of participants):	**26877.60**
Average Length of Stay on the Waiver:	356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
One-Time Transitional Services Total:						**24000.00**
One-Time Transitional Services	Per Package	8	1.00	3000.00	**24000.00**	
Personal Emergency Response System Total:						**2702.40**
Personal Emergency Response System	Monthly	8	12.00	28.15	**2702.40**	
Professional Services Total:						**8136.00**
Licensed Clinical Social Work	15 minutes	4	24.00	7.50	**720.00**	
Registered Dietician	15 minutes	4	24.00	9.00	**864.00**	
Occupational Therapy	15 minutes	4	24.00	12.00	**1152.00**	
Speech Therapy	15 minutes	4	24.00	11.25	**1080.00**	
Psychology	15 miniutes	4	24.00	31.25	**3000.00**	
Physical Therapy	15 minutes	4	24.00	13.75	**1320.00**	
Transportation - Community Access Total:						**1204.32**
Transportation - Community Access	One-way trip	4	52.00	5.79	**1204.32**	
				GRAND TOTAL:		**6047459.69**
				Total Estimated Unduplicated Participants:		**225**
				Factor D (Divide total by number of participants):		**26877.60**
				Average Length of Stay on the Waiver:		**356**

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
Day Habilitation Total:						**253598.00**
Day Habilitation	2.5 hours	46	298.00	18.50	**253598.00**	
Prevocational Services Total:						**182677.50**
Prevocational Services	2.5 hours	23	353.00	22.50	**182677.50**	
Respite Services - Out of Home Total:						**1111.68**
Respite Services - Out of Home	15 minutes		24.00	3.86	**1111.68**	
				GRAND TOTAL:		**8638048.94**
				Total Estimated Unduplicated Participants:		**325**
				Factor D (Divide total by number of participants):		**26578.61**
				Average Length of Stay on the Waiver:		**356**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		12				
Shared Living Services Total:						**3247335.00**
Shared Living Services	Per Diem	182	305.00	58.50	**3247335.00**	
Support Coordination Total:						**622635.00**
Support Coordination	15 minutes	325	103.00	18.60	**622635.00**	
Supported Employment Total:						**16536.00**
Supported Employment	15 minutes	30	212.00	2.60	**16536.00**	
Assistive Technology/Specialized Medical Equipment and Supplies Total:						**2772.00**
Assistive Technology/Specialized Medical Equipment and Supplies	Per Item	12	1.00	231.00	**2772.00**	
Dental Total:						**2119.32**
Dental	Per Procedure	12	3.00	58.87	**2119.32**	
Community Living Supports Total:						**3494430.98**
Community Living Supports	15 minutes	53	17081.00	3.86	**3494430.98**	
Companion Care Total:						**179580.00**
Companion Care	Per Diem	12	365.00	41.00	**179580.00**	
Environmental Accessibility Adaptations Total:						**149257.80**
Environmental Accessibility Adaptations	Per Item	12	3.00	4146.05	**149257.80**	
Host Home Total:						**4725.70**
Host Home	Per Diem	86	1.00	54.95	**4725.70**	
Housing Stabilization Service Total:						**2175.84**
Housing Stabilization Service	15 minutes	2	72.00	15.11	**2175.84**	
Housing Stabilization Transition Service Total:						**2810.46**
Housing Stabilization Transition Service	15 minutes	2	93.00	15.11	**2810.46**	
Nursing Total:						**408209.10**
Nursing	15 minutes	30	1703.00	7.99	**408209.10**	
One-Time Transitional Services Total:						**36000.00**
One-Time Transitional Services	Per Package	12	1.00	3000.00	**36000.00**	
Personal Emergency Response System Total:						**4053.60**
Personal Emergency Response System	Monthly	12	12.00	28.15	**4053.60**	

GRAND TOTAL:	**8638048.94**
Total Estimated Unduplicated Participants:	**325**
Factor D (Divide total by number of participants):	**26578.61**
Average Length of Stay on the Waiver:	356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Professional Services Total:						24408.00
Licensed Clinical Social Work	15 minutes	12	24.00	7.50	2160.00	
Registered Dietician	15 minutes	12	24.00	9.00	2592.00	
Occupational Therapy	15 minutes	12	24.00	12.00	3456.00	
Speech Therapy	15 minutes	12	24.00	11.25	3240.00	
Psychology	15 minutes	12	24.00	31.25	9000.00	
Physical Therapy	15 minutes	12	24.00	13.75	3960.00	
Transportation - Community Access Total:						3612.96
Transportation - Community Access	One-way trip	12	52.00	5.79	3612.96	
				GRAND TOTAL:		8638048.94
				Total Estimated Unduplicated Participants:		325
				Factor D (Divide total by number of participants):		26578.61
				Average Length of Stay on the Waiver:		356

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
Day Habilitation Total:						292189.00
Day Habilitation	2.5 hours	53	298.00	18.50	292189.00	
Prevocational Services Total:						595687.50
Prevocational Services	2.5 hours	75	353.00	22.50	595687.50	
Respite Services - Out of Home Total:						1111.68
Respite Services - Out of Home	15 minutes	12	24.00	3.86	1111.68	
Shared Living Services Total:						4603365.00
Shared Living Services	Per Diem	258	305.00	58.50	4603365.00	
Support Coordination Total:						814215.00
Support Coordination	15 minutes		103.00	18.60	814215.00	
				GRAND TOTAL:		11390188.81
				Total Estimated Unduplicated Participants:		425
				Factor D (Divide total by number of participants):		26800.44
				Average Length of Stay on the Waiver:		356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		425				
Supported Employment Total:						**30316.00**
Supported Employment	15 minutes	55	212.00	2.60	**30316.00**	
Assistive Technology/Specialized Medical Equipment and Supplies Total:						**2772.00**
Assistive Technology/Specialized Medical Equipment and Supplies	Per Item	12	1.00	231.00	**2772.00**	
Dental Total:						**2119.32**
Dental	Per Procedure	12	3.00	58.87	**2119.32**	
Community Living Supports Total:						**3955959.60**
Community Living Supports	15 minutes	60	17081.00	3.86	**3955959.60**	
Companion Care Total:						**179580.00**
Companion Care	Per Diem	12	365.00	41.00	**179580.00**	
Environmental Accessibility Adaptations Total:						**149257.80**
Environmental Accessibility Adaptations	Per Item	12	3.00	4146.05	**149257.80**	
Host Home Total:						**5220.25**
Host Home	Per Item	95	1.00	54.95	**5220.25**	
Housing Stabilization Service Total:						**4351.68**
Housing Stabilization Service	15 minutes	4	72.00	15.11	**4351.68**	
Housing Stabilization Transition Service Total:						**5620.92**
Housing Stabilization Transition Service	15 minutes	4	93.00	15.11	**5620.92**	
Nursing Total:						**680348.50**
Nursing	15 Minutes	50	1703.00	7.99	**680348.50**	
One-Time Transitional Services Total:						**36000.00**
One-Time Transitional Services	Per Package	12	1.00	3000.00	**36000.00**	
Personal Emergency Response System Total:						**4053.60**
Personal Emergency Response System	Monthly	12	12.00	28.15	**4053.60**	
Professional Services Total:						**24408.00**
Licensed Clinical Social Work	15 minutes	12	24.00	7.50	**2160.00**	
Registered Dietician	15 minutes	12	24.00	9.00	**2592.00**	
Occupational Therapy					**3456.00**	

GRAND TOTAL:	**11390188.81**
Total Estimated Unduplicated Participants:	**425**
Factor D (Divide total by number of participants):	**26800.44**
Average Length of Stay on the Waiver:	356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 minutes	12	24.00	12.00		
Speech Therapy	15 minutes	12	24.00	11.25	3240.00	
Psychology	15 minutes	12	24.00	31.25	9000.00	
Physical Therapy	15 minutes	12	24.00	13.75	3960.00	
Transportation - Community Access Total:						3612.96
Transportation - Community Access	One-way trip	12	52.00	5.79	3612.96	
				GRAND TOTAL:		11390188.81
				Total Estimated Unduplicated Participants:		425
				Factor D (Divide total by number of participants):		26800.44
				Average Length of Stay on the Waiver:		356

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
Day Habilitation Total:						413475.00
Day Habilitation	2.5 hours	75	298.00	18.50	413475.00	
Prevocational Services Total:						754537.50
Prevocational Services	2.5 hours	95	353.00	22.50	754537.50	
Respite Services - Out of Home Total:						1760.16
Respite Services - Out of Home	15 minutes	19	24.00	3.86	1760.16	
Shared Living Services Total:						5905867.50
Shared Living Services	Per Diem	331	305.00	58.50	5905867.50	
Support Coordination Total:						1005795.00
Support Coordination	15 minutes	525	103.00	18.60	1005795.00	
Supported Employment Total:						33072.00
Supported Employment	15 minutes	60	212.00	2.60	33072.00	
Assistive Technology/Specialized Medical Equipment and Supplies Total:						4389.00
				GRAND TOTAL:		14527531.62
				Total Estimated Unduplicated Participants:		525
				Factor D (Divide total by number of participants):		27671.49
				Average Length of Stay on the Waiver:		356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology/Specialized Medical Equipment and Supplies	Per Item	19	1.00	231.00	4389.00	
Dental Total:						3355.59
Dental	Per Procedure	19	3.00	58.87	3355.59	
Community Living Supports Total:						4944949.50
Community Living Supports	15 minutes	75	17081.00	3.86	4944949.50	
Companion Care Total:						284335.00
Companion Care	Per Diem	19	365.00	41.00	284335.00	
Environmental Accessibility Adaptations Total:						236324.85
Environmental Accessibility Adaptations	Per Item	19	3.00	4146.05	236324.85	
Host Home Total:						5495.00
Host Home	Per Diem	100	1.00	54.95	5495.00	
Housing Stabilization Service Total:						4351.68
Housing Stabilization Service	15 minutes	4	72.00	15.11	4351.68	
Housing Stabilization Transition Service Total:						5620.92
Housing Stabilization Transition Service	15 minutes	4	93.00	15.11	5620.92	
Nursing Total:						816418.20
Nursing	15 minutes	60	1703.00	7.99	816418.20	
One-Time Transitional Services Total:						57000.00
One-Time Transitional Services	Per Package	19	1.00	3000.00	57000.00	
Personal Emergency Response System Total:						6418.20
Personal Emergency Response System	Monthly	19	12.00	28.15	6418.20	
Professional Services Total:						38646.00
Licensed Clinical Social Work	15 minutes	19	24.00	7.50	3420.00	
Registered Dietician	15 minutes	19	24.00	9.00	4104.00	
Occupational Therapy	15 minutes	19	24.00	12.00	5472.00	
Speech Therapy	15 minutes	19	24.00	11.25	5130.00	
Psychology	15 minutes	19	24.00	31.25	14250.00	
Physical Therapy	15 minutes		24.00	13.75	6270.00	

GRAND TOTAL:	14527531.62
Total Estimated Unduplicated Participants:	525
Factor D (Divide total by number of participants):	27671.49
Average Length of Stay on the Waiver:	356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		19				
Transportation - Community Access Total:						**5720.52**
Transportation - Community Access	One-way trip	19	52.00	5.79	**5720.52**	
GRAND TOTAL:						**14527531.62**
Total Estimated Unduplicated Participants:						**525**
Factor D (Divide total by number of participants):						**27671.49**
Average Length of Stay on the Waiver:						356

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
Day Habilitation Total:						**490657.00**
Day Habilitation	2.5 hours	89	298.00	18.50	**490657.00**	
Prevocational Services Total:						**833962.50**
Prevocational Services	2.5 hours	105	353.00	22.50	**833962.50**	
Respite Services - Out of Home Total:						**84.92**
Respite Services - Out of Home	15 minutes	22	1.00	3.86	**84.92**	
Shared Living Services Total:						**7368952.50**
Shared Living Services	Per Diem	413	305.00	58.50	**7368952.50**	
Support Coordination Total:						**1197375.00**
Support Coordination	15 minutes	625	103.00	18.60	**1197375.00**	
Supported Employment Total:						**41340.00**
Supported Employment	15 minutes	75	212.00	2.60	**41340.00**	
Assistive Technology/Specialized Medical Equipment and Supplies Total:						**5082.00**
Assistive Technology/Specialized Medical Equipment and Supplies	Per Item	22	1.00	231.00	**5082.00**	
Dental Total:						**3885.42**
Dental	Per Procedure	22	3.00	58.87	**3885.42**	
Community Living Supports Total:						**5604276.10**
GRAND TOTAL:						**17312046.35**
Total Estimated Unduplicated Participants:						**625**
Factor D (Divide total by number of participants):						**27699.27**
Average Length of Stay on the Waiver:						356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Living Supports	15 minutes	85	17081.00	3.86	5604276.10	
Companion Care Total:						329230.00
Companion Care	Per Diem	22	365.00	41.00	329230.00	
Environmental Accessibility Adaptations Total:						273639.30
Environmental Accessibility Adaptations	Per Item	22	3.00	4146.05	273639.30	
Host Home Total:						5769.75
Host Home	Per Diem	105	1.00	54.95	5769.75	
Housing Stabilization Service Total:						5439.60
Housing Stabilization Service	15 minutes	5	72.00	15.11	5439.60	
Housing Stabilization Transition Service Total:						7026.15
Housing Stabilization Transition Service	15 minutes	5	93.00	15.11	7026.15	
Nursing Total:						1020522.75
Nursing	15 minutes	75	1703.00	7.99	1020522.75	
One-Time Transitional Services Total:						66000.00
One-Time Transitional Services	Per Package	22	1.00	3000.00	66000.00	
Personal Emergency Response System Total:						7431.60
Personal Emergency Response System	Monthly	22	12.00	28.15	7431.60	
Professional Services Total:						44748.00
Licensed Clinical Social Work	15 minutes	22	24.00	7.50	3960.00	
Registered Dietician	15 minutes	22	24.00	9.00	4752.00	
Occupational Therapy	15 minutes	22	24.00	12.00	6336.00	
Speech Therapy	15 minutes	22	24.00	11.25	5940.00	
Psychology	15 minutes	22	24.00	31.25	16500.00	
Physical Therapy	15 minutes	22	24.00	13.75	7260.00	
Transportation - Community Access Total:						6623.76
Transportation - Community Access	One-way trip	22	52.00	5.79	6623.76	
				GRAND TOTAL:		17312046.35
				Total Estimated Unduplicated Participants:		625
				Factor D (Divide total by number of participants):		27699.27
				Average Length of Stay on the Waiver:		356

	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.i.a.4. Number and percentage of critical incidents where all necessary follow-up was completed and appropriate actions were taken as measured by closure of the critical incident. Percentage = Number of critical incidents that were closed in the system appropriately / Total number of critical incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Online Tracking Incident System (OTIS)

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group: