◉ **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:

LDH Health Standards Section is responsible for receiving, responding to and determining the necessity of and/or scope of investigation for all complaints in which the allegations involve potential non-compliance of Home and Community Based (HCBS) licensing standards by the direct service provider.

The LGEs are responsible for receiving, reporting, and responding to complaints received for individuals supported through the waiver in which the allegations involve alleged violations of waiver policy by the direct service provider and/or non-regulatory matters that are not handled by Health Standards.

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 Office for Citizens with Developmental Disabilities (OCDD) is responsible for receiving, reporting and responding to customer complaints received for people supported through their office including those supported through the NOW in which the allegations involve alleged violations of waiver policy by the direct service provider and/or non-regulatory matters that are not handled by Health Standards. A complaint is a concern, dissatisfaction, or dispute expressed through written or verbal communication or expressed through other means, such as assistive devices, regarding: care, supports and services, action or inaction of staff, department or agency requirement, regulation or policy or other circumstances affecting quality of care or quality of life, including allegations of rights of violations. Each OCDD entity including LGEs or 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 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 an OCDD entity the complaint is reviewed to determine if the complaint can be resolved by OCDD or if the complaint needs to be referred to another agency (Bureau of Health Services Financing, 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 fifteen calendar days of receipt of the complaint, unless an extension is granted. 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 entities will continue to follow up with other agencies regarding complaint action/resolution. All complaints are entered into a database for tracking of complaints and quality management purposes.
Each OCDD entity will utilize complaint data from the complaint database to conduct quality reviews. A sample size of complaints is reviewed based on the number of complaints received and resolved each quarter. The reviews

shall include contacting the complainants to assure their satisfaction with the resolution. The reports generated from the complaints database shall be evaluated to identify trends and patterns for determining appropriate strategies for improving services.

OCDD State Office shall conduct oversight activities to assure that OCDD entities comply with policy guidelines. At least five percent of the total complaints from OCDD entities are reviewed quarterly to assess whether the complaints were addressed according to requirements. Reports are evaluated to identify trends and patterns and to make recommendations for training, technical assistance or strategies for improving services
The Health Standards Section (HSS) is responsible for the operation of grievance/complaints that involve the potential non-compliance of Home and Community Based licensing standards by the direct service provider.
• The HSS State Office maintains a toll free complaint line for receipt of complaints involving waiver participants as well as other home and community based services such as those provided through Medicaid State plan.
• The nature and scope of the complaint is at the discretion of the individual registering the complaint.
• The Health Standards toll free complaint line number, the LGE complaint line number and the number for protective services is printed on business cards, brochures, and fact sheet along with directions on what number to call depending upon the allegations being reported. It is given to participants and their legal representative(s) at intake by their support coordinator. During the pre-certification visit the LGE 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 LGE staff, as well as support agencies such as Families Helping Families distribute the HSS, LGE and protective services contact information when assisting participants and their legal representative(s). Direct service providers are also required to give the toll free numbers 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. LGE staff checks to make sure that this information has been relayed to them during the pre-certification visit.
• If LGE 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 entity staff will review and consider the information provided by the complainant and make a determination as to whether the complaint can be resolved by the LGE or whether additional action is required by HSS. If it is determined that there is evidence of non-compliance of the HCBS Licensing Standards, the LGE will refer the complainant to the HSS Complaint line within 24 hours.
• HSS and the LGE 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 applicable protective services agency.
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 with HCBS licensing standards, HSS will investigate by on site visit or administrative desk review. A written report is sent 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 as required by Louisiana Revised Statute 14:403.2, which defines reporting criteria pertaining to any known or suspected abuse, neglect, exploitation or extortion, by the discoverer of the incident immediately upon discovery to the appropriate protective services agency for review and follow-up action are:

- •Abuse (adult), as defined in Louisiana Revised Statute15:503.
- •Abuse (child), as defined in Louisiana Children's Code, Article 1003.
- •Exploitation (adult), as defined in Louisiana Revised Statute15:503.
- •Extortion (adult), as defined in Louisiana Revised Statute 15:503.
- •Neglect (adult), as defined in Louisiana Revised Statute 15:503.
- •Neglect (child), as defined in Children's Code, Article 1003.

The following categories of incidents as defined in OCDD Operational Instruction #F-5: Critical incident reporting, Tracking and Follow-up Activities for waiver Services are required to be reported in the incident reporting system by the provider :

- •Death
- •Fall
- •Involvement with Law Enforcement
- •Loss or Destruction of Home
- •Major Behavioral Incident
- •Major Illness
- •Major Injury
- •Missing
- •Restraint Use

The provider must verbally notify the support coordinator of a critical incident as soon as possible after taking all necessary actions to protect the participant from further harm and responding to the emergency needs of the participant.

Additionally, The Direct Service Provider (DSP) staff must notify the DSP Supervisor. The provider must submit a written critical incident report via the incident reporting system within 24 hours of the incident discovery.

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.

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 protective services toll-free lines and the Health Standards Section (HSS) complaint line to the participant and his/her legal representatives. The support coordinator reviews the participant's rights and responsibilities and gives the participant a copy of the OCDD Rights and Responsibilities for Applicants/Recipients of a Home and Community Based Waiver. The support coordinator confirms that the participant and his/her legal representative(s) have the protective services toll-free lines and HSS complaint line number at the quarterly face-to-face visits. The support coordinator also provides this information at any other time the participant or his/her authorized representative request it.

During the Pre-Certification Visit the Local Governing Entity (LGE) staff will review information about the right to be free of abuse and neglect with the participant and his/her legal representative, make sure that they have phone numbers for the protective services toll-free lines, HSS complaint line, the LGE office number, and the support coordination agency number 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/Recipients of a Home and

Community Based Waiver.

Each provider is required by HSS licensing regulations to have a written orientation program for participants being admitted to their programs that include participant rights and responsibilities, grievance and appeal procedures,and 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 critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

When a critical incident occurs, the following actions are taken:
Provider:
•Assures that the participant is protected from further harm and must respond to any emergency needs of the participant. The provider must review each critical incident and record remedial actions taken in response to the incident within twenty-four (24) hours of the discovery of the incident.
•Cooperates with the appropriate protective service agency once an investigation commences if abuse/neglect/exploitation/extortion is reported. Supplies relevant information, records, and access to members of the agency conducting the investigation.
•Participates in planning meetings to resolve each critical incident or to develop strategies to prevent or mitigate the likelihood of similar incidents in the future.
•Tracks critical incidents and outcomes in order to identify remediation needs and quality improvement goals and to determine the effectiveness of strategies employed for incident resolution.

Support Coordinator:
•Takes immediate action to assure the participant is protected from further harm and respond to any emergency needs of the participant;
•Monitors critical incidents entered into the incident reporting system by the provider on a daily basis;
•Contacts the DSP within two (2) hours of discovery when the incident is discovered by the Support Coordinator,
•Reports incidents involving abuse, neglect, exploitation, and extortion to Protective Services.
•Enters critical incident report information into the incident reporting system by close of business the next business day after notification of a critical incident;
•Enters follow-up case note by close of the sixth business day after initial report;
•Continues to follow up with the DSP agency, the participant, and others, as necessary, and updates in the incident reporting system with case notes until the incident is resolved and the case is closed;
•Convenes any planning meetings that may be needed to resolve the critical incident or develop strategies to prevent or mitigate the likelihood of similar critical incidents occurring in the future and revise the POC accordingly;
•Sends the participant and DSP a copy of the Incident Participant Summary within fifteen (15) days after Final Supervisory Review and Closure by the Regional Office. It does not include the identity of the Reporter or any sensitive or unsubstantiated allegations. The Participant Summary is not distributed in the event of deaths;
•For Transfer of Open Cases, the transferring support coordination agency must supply the accepting agency with the incident number(s) at the time of Transfer of Records. Additionally, they must notify the regional waiver office. The accepting agency must review, assign, take actions to resolve the incident, and enter into the case record in the incident reporting system until closure of the incident.
•Tracks critical incidents to identify remediation needs and quality improvement goals and to determine the effectiveness of strategies employed.

Local Governing Entity (LGE):
•Reviews all new incoming critical incident reports in the incident reporting system on a daily basis, determines the report priority level (i.e., urgent or non-urgent), and assigns the report to staff within 1 business day for monitoring /follow-up.
•Assures that all activities occur within required timelines as detailed in OCDD Operational Instruction F-5;
•Provides technical assistance to the support coordinator when timelines are not being met or the support coordinator reports an inability to identify necessary resources. Assists in making referrals to additional referral resources as needed;
•Immediately reports the incident to the appropriate protective service agency if the LGE suspects or becomes aware that a critical incident meets the definition of abuse, neglect, exploitation or extortion, and there is no documentation that the allegation has been reported to the appropriate protective services agency;
•Conducts follow-up monitoring of critical incidents where remedial actions required revision of the plan of care;

•Closes critical incident cases after all necessary follow-up has occurred and documented in the critical incident report, within 30 days. The LGE may grant extensions to incidents in these categories as permitted in OCDD Operational Instruction F-5.

Child Protective Services (CPS) (ages 0 to 17):
•Investigates allegations or reports of abuse, neglect or exploitation by a family member or legal guardian involving any child aged 0-17 years,, based upon CPS policies and guidelines,
•Develops a protective plan and retains the authority to remove the minor participant from the home setting for his/her safety. The LGE waiver offices will coordinate continued waiver services contingent on CPS plan of protection.

Adult/Elderly Protective Services (APS/EPS): (ages 18 and above, and emancipated minors):
•Investigates allegations of abuse, neglect, exploitation, or extortion involving a participant aged 18 and older when the alleged perpetrator is a family member, legal guardian, or other natural support person not employed by a provider agency, based upon APS policies and guidelines.

Health Standards Section (HSS):
•HSS investigates allegations or reports of abuse, neglect, exploitation, or extortion when the alleged perpetrator is a provider agency owner or employee , based upon their internal policy and guidelines.

Law Enforcement:
•The provider and support coordinator are required to ensure that they contact law enforcement in the event of any allegation of child abuse or neglect involving participants under the age of 18. Protective services contacts law enforcement in the event of a substantiated case of abuse or neglect according to their policies and procedures.
•In the event of a participant's arrest for a crime, the provider and support coordinator contact law enforcement to assure that information about the participant's health needs, medications or other risk factors are conveyed to assure safety while in police custody.

OCDD State Office:
•Provides technical assistance to LGEs when all attempts to mitigate harm have been exhausted;
•Collaborates with protective service agencies, Health Standards, law enforcement and the judicial system to assure coordination of activities to mitigate harm in individual cases;
•Monitors timely closure of critical incidents and adherence to OCDD critical incident operational instructions by the LGEs;
•Conducts monthly Clinical Review Committee (CRC) case reviews for participants who experience repeated critical incidents as defined in OCDD Operational Instruction #F-8 Risk Management Process for Waiver Services: Critical Incident Reviews. CRC has the authority to issue recommendations for further action to providers, support coordination agencies and LGEs when it is discovered that practices by any one or combination of these entities have not sufficiently assured mitigation of potential harm. CRC may, at its discretion, request a follow-up report on progress towards mitigation within 60 day timeline;
•Conducts monthly Mortality Review Committee (MRC) meetings to analyze deaths of waiver participants, as described in OCDD Operational Instruction #F-1 Mortality Review for Waiver Participants. MRC has the authority to issue a request for corrective action to providers, support coordination agencies and LGEs when it is discovered that practices by any one or combination of these entities could potentially affect other participants negatively. The MRC request for corrective action can be issued in conjunction with corrective action plans issued by Health Standards. Corrective action plans are due 30 days from receipt of the request from MRC.

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 between OCDD and LGEs delegates the day to day responsibility for oversight of the reporting and response to critical incidents or events that affect waiver participants.

OCDD maintains the services of support coordination agencies through contracts that stipulate the requirements for compliance with waiver regulations.

OCDD State Office Quality Section analyzes trends and patterns in critical incident reports to identify potential

quality enhancement goals and utilizes the critical incident data to determine the effectiveness of OCDD Quality Enhancement strategies.

OCDD provides the State Medicaid Agency with aggregate quarterly reports which are used to identify trends and patterns.

The State Medicaid Agency oversees the maintenance and continual upgrading of the on-line critical incident reporting system.

Frequency of oversight activities:
The LGE, on a monthly basis, will pull 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 and perform annual analysis of data to determine the effectiveness of quality enhancement goals and activities.

OCDD State Office conducts monthly performance reviews of the analysis of 100% of critical incidents produced by the Quality Section and determines quality enhancement initiatives.

MPSW provides oversight and remediation enforcement of critical incident management through the Medicaid HCBS Oversight Committee which meets quarterly to review current performance reports for the all waiver assurances including health and welfare. Quality recommendations or issues which cannot be resolved at this level are placed on the agenda of the Medicaid/Program Offices Quarterly Meeting.

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).

LDH BHSF HCBS Providers Minimum Licensing Standards(LAC 48:I.Chapter 50)§5029 establishes prohibitions to the use of chemical restraints,physical & mechanical restraints,seclusion or any procedure which denies food, drink, visits with family,or use of rest room facilities. Enrolled providers of waiver services are required to ensure that non-intrusive, positive approaches to address the meaning/origins of behaviors are used prior to the development of a restrictive plan,& cover any behavioral emergency & provide documentation of the event in an IR format. Restraint is a reportable CI as described in OCDD OI F-5: Critical Incident Reporting, Tracking & Follow-up Activities for Waiver Services.
•If a protective hold must be used,DSP staff will notify the SC verbally no later than 2 hours after the incident or discovery of the incident & report in writing via CIR system within 24 hours,following appropriate reporting procedures.
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 CI.
Restraint use categories:
•Behavioral:restraints used to suppress a person's behavior & don't include restraints used when conducting a medical treatment. May be planned or unplanned. May involve personal, mechanical,or chemical restraints. Includes a protective hold.
•Medical:restraints 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 OCDD provides MPSW with aggregate data & reports which are inclusive of any reported restraint use.
•Enrolled providers 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 & after other, less restrictive interventions/strategies have failed. Protective holds may only be implemented by trained staff & of short duration. OCDD has a Policy on Restraint & Seclusion #701 issued 3/6/03.
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 & competence in methods for minimizing the use of restraint & safely applying restraint & in policies concerning the use of restraint.
•Enrolled providers 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.
•DSP staff are required to have initial & annual training in the management of aggressive behavior,this includes acceptable & prohibited responses,crisis de-escalation,& safe methods for protecting the person & 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 SC verbally immediately or within 2 hours of discovery & report in writing via CIR within 24 hours,following appropriate reporting procedures.
•The SC will contact the participant & his/her legal representatives within 24 hours of receiving the CIR involving a physical hold. Changes to the POC or living situation will be considered to support the person's safety & well-being. Follow-up visits with the participant & his/her legal representatives are conducted & include questions about any actions taken by a DSP that may qualify as unauthorized use or misapplication of physical restraints.
•Unauthorized use of restraints is detected through the licensing & surveying process that HSS conducts,as a result of the SC's monthly contacts with participants & their legal representative(s),or as a result of receipt of a CIR 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. 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 & procedures are incorporated in the POC if use is anticipated based on the participant's behavioral trends & patterns. Behavioral challenges are addressed in an ongoing plan that utilize other appropriate & less restrictive techniques to prevent the problems,de-escalate them when they occur,& teach appropriate options/coping skills/replacement behaviors.
The DSP is responsible for reviewing incidents & trends while OCDD is responsible for reviewing DSP practices & use of protective supports & procedures. Incidents reaching a specified threshold will be reviewed by the OCDD CRC.
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 & as a result,the techniques will vary,but may include:
Preventive strategy examples:
1.Identification of triggers for the challenging behavior & avoidance of triggers(i.e.,noise may be a trigger so efforts are made to avoid loud/crowded spaces);&
2.Identification of things the participant enjoys & times/activities during which the challenging behavior is least likely to occur & 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 & then teaching staff to recognize the early signs of agitation & how to prompt use of the new coping skills; &
2.Reinforcing exhibition of appropriate behavior identified in the plan)& 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;&
2.Removing objects that may be used aggressively.
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 & is developed by various professionals.
Restraint use 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 & benefits of the plan. 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. 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 &/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,& 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 & 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 & 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 & methods for implementing emergency restraints when necessary as a last resort. Required competencies include demonstration of OCDD's philosophy & policy re:use of restraints & 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 & 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 & 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, & 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:

•Providers are required to report measures implemented to mitigate the use of restraints and follow-up in regards to referrals to protective services (if necessary), changes to behavior supports, or staff training. The provider is responsible for reviewing incidents for trends and patterns within its own agency caseload to determine what quality initiatives may be necessary to provide alternate means of addressing situations which result in restraint at least quarterly.
The support coordination agency is responsible for tracking trends in restraint incidents involving providers who serve participants on the support coordination agency caseload at least quarterly. The support coordinator is responsible for addressing behavioral needs on a quarterly basis and amending the plan of care to ensure positive support strategies are implemented.
LGEs are responsible for quarterly monitoring the reviews conducted by SCAs, to provide technical assistance and assist with referrals for additional services when necessary.
OCDD is responsible for reviewing aggregate data in the critical incident reporting system on the use of protective supports and procedures.
OCDD will present aggregate data to the OCDD Performance Review Committee to determine if any quality initiatives are necessary.
OCDD will provide MPSW with aggregate data and reports which are inclusive of any reported restraint use, remediation strategies and quality improvement initiatives and the results of quality improvement projects on a quarterly basis.

Appendix G: Participant Safeguards

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

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

◉ **The State does not permit or prohibits the use of restrictive interventions**

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

The 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 and support coordinator unannounced visits.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

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

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

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

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

Appendix G: Participant Safeguards

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

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

a. **Applicability.** Select one:

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

b. **Medication Management and Follow-Up**

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

If the participant does not self-administer, or if medication is not administered by family, a register nurse shall authorize and monitor medication administration and noncomplex task performed by the DSW in accordance with LAC 48:I. Chapter 92 published in the Louisiana Register, Vol. 38, No. 12, December 20, 2012.

Medication administration can only be delegated to a DSW by an RN if the participant receives daily monitoring by a family member, direct service worker, and/or other health care providers for the purposes of collecting critical information needed to assure the individual's welfare. Additionally, the participant health status must be stable and predictable as determined by the RN.

The direct service worker shall receives periodic assessment by a RN based on the person's health status and specified within the plan of care; in no case shall the periodic assessment be less than annually. A comprehensive assessment performed for a client in accordance with policies and procedures established by Medicaid or by a LDH program office may serve as the basis of the RN assessment but may not be used in lieu of the RN assessment.

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.

The LDH Office of Management and Finance, Health Standards Section conducts a survey/monitoring of provider agencies, which includes a review of participant's records. This review includes an assessment of services provided and their outcomes. Types of services reviewed include medications and treatments ordered by physicians and medication administration by unlicensed direct service workers. For every provider agency surveyed, HSS ensures all licensing regulations are followed for participants records reviewed, including medication administration. If citations are issued due to non-compliance, HSS issues a statement of deficiency and requires a corrective action plan.

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).

Louisiana Department of Health Bureau of Health Services Financing Direct Service Worker Registry (LAC 48:I. Chapter 92) provides for general requirements for the performance of medication administration and noncomplex tasks.

The Support Coordinator is responsible for including medications, entity responsible for medication administration, and oversight into the participant's plan of care.

Unlicensed direct care staff that performs administration of medications or procedures may currently do so

under Registered Nurse (RN) delegation. The RN signs a written document which indicates the participant's procedures, medications, dosages, site of administration and instructions. This document verifies that the delegating RN 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 RN's authority. Each provider agency's administration has the responsibility for conducting on-site visits and assessments of all employees delegated by the RN 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 Nurse Delegation training.

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 critical incident reporting system, which is accessed by the Health Standards Section and OCDD with follow-up for conducting corrective actions via the LGE staff 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.

If the error does NOT result in medical attention by a physician, nurse, dentist or any licensed health care provider, then the provider is required to record the error, but is not required to report the error to the State via the critical incident reporting process.

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

Major medication incidents which include, 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 must be reported to the State via the critical incident reporting process.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

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

LDH Office of Management and Finance, Health Standards Section (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 critical incident reporting system is a 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. The system allows real-time access to information for OCDD, MPSW, LGE, 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 LGE 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 the LGE's ongoing, real-time reviews of 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 State Office and the LGE. As these medication-related concerns surface, the LGE staff follow up to assure that appropriate corrective actions have been implemented by waiver providers. The LGE staff follow up to critical incidents involving medication is entered into the incident reporting system data base which is automatically accessible to the State Medicaid Agency (SMA) 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).

MPSW 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 MPSW. MPSW 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 MPSW will meet with the operating agency to address any changes needed to remediation strategies in order to improve results. The MPSW 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 is 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. Number and percentage of substantiated abuse,neglect or exploitation cases where required remediation is completed, as measured by case closure in the incident reporting system. Numerator = Number of substantiated incidents of abuse,neglect or exploitation where required remediation was completed;Denominator = Total number of substantiated allegations.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **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 deaths requiring a corrective action plan where the corrective action plan was completed as measured by closure of the critical incident in the incident reporting system. Numerator = Number of deaths requiring a corrective action plan where the corrective action plan was completed; Denominator = Total number of deaths requiring corrective action plan.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **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 substantiated abuse/immediate jeopardy complaint investigations initiated within 2 working days of receipt by Health Standards. Percentage= Number of substantiated abuse/immediate jeopardy complaint investigations initiated within 2 working days of receipt by Health Standard /Total number of substantiated abuse/immediate jeopardy complaints

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: Health Standards Section	☐ **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: Health Standards Section	☑ **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 is analyzed statistically/deductively or inductively, how

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.a.i.b.1. Number and percentage of critical incidents where all follow-up was completed and proper actions were taken as measured by closure of the critical incident within OCDD's specified timelines . Numerator = Number of critical incidents with completed follow-up and proper action were taken as measured by closure of the critical incident; Denominator = Total number of critical incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Reporting 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:	☐ **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:

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

Performance Measures

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

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

Performance Measure:
G.a.i.c.1. Number and percentage of reported use of restraints where appropriate follow-up has been completed as measured by case closure. Numerator = Number of reported use of restraints where appropriate follow-up has been completed as measured by case closure; Denominator = Total number of reported use of restraints.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Reporting 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:	☐ **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:

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

Performance Measures

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

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

Performance Measure:
G.a.i.d.1 Number and percent of participants who received the coordination and support to access health care services identified in their service plan. Numerator = Number of participants who received the coordination and support to access health care services identified in their service plan; Denominator = Total number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LASCA

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Support coordination agencies periodically conduct unannounced visits to participant homes. If a concern is identified during the unannounced visit, then the LGE is notified by the SCA, and the LGE may request a plan of correction from the provider agency.

If a complaint is received by OCDD or the LGEs that has the potential to affect the health and welfare of a participant then the Support Coordinator is notified to conduct an unannounced health and welfare check of all NOW participants served by the direct service provider. If additional problems are discovered that affect the health and safety of participants, then a complaint is reported to the Health Standards Section for follow-up.

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.
For Performance Indicators G.a.i.a.1, G.a.i.a.2, G.a.i.b.1, G.a.i.c.1
There are several layers of remediation to address the issues identified in a Critical Incident Report (CIR). They include:
• Primary remediation occurs at the level of the provider agency, where immediate response is required in halting and correcting harmful, dangerous or potentially harmful or dangerous conditions at the time the condition is discovered.
• The support coordinator is responsible for determining any further remediation that can be implemented by way of strategies developed in team meetings with the participant and axillary support services.
• The LGE waiver offices are responsible for reviewing individual critical incidents on a daily basis involving death, attempted suicide, and major illness resulting in hospitalization for pneumonia, bowel obstruction, and uncontrolled seizures and assuring that support coordinators follow through as described in the previous paragraph. The LGE provides technical support to support coordinators as necessary.
• OCDD State Office Quality Section conducts individual reviews of incidents involving waiver participants that meet the threshold for involvement at that level as required in OCDD policy. OCDD State Office generates recommendations to the LGE where each participant resides to further assist in remediation. All critical incidents are tracked for closure by OCDD State Office. If during the OCDD periodic review an LGE fails to close a CIR within the appropriate timelines, then OCDD may request a Corrective Action Plan for improvement.
Performance Indicator G.a.i.a.1
• Remediation of individual cases of substantiated abuse, neglect or exploitation is determined by the appropriate protective services agency (dependent on the waiver participant's age) and/or the LDH Health Standards Section as required in their policies and procedures.
Performance Indicator G.a.i.a.2
• The OCDD conducts individual reviews of all incidents resulting in the death of the waiver participant through the Mortality Review Committee. OCDD may determine the provider and/or support coordinator could improve services, and require a corrective action plan. Follow-up corrective action is also documented in the case file.

Performance Indicator G.a.i.a.3
• If the Health standards does not initiate the appropriate on-site investigation within 2 working days, then the matter is referred to the Medicaid Program Office Quarterly Meeting or the HCBS Oversight Committee. Health Standards will be invited on an ad hoc basis if this performance indicator requires remediation.
Performance Indicator G.a.i.d.1
LGE staff perform monitoring of Support Coordinator Agencies (SCA) at least annually utilizing the OCDD Support Coordination Monitoring Tools: Participant Interview; Participant Record Review; Support Coordinator Interview; and Agency Review. The processes for scoring and determining the necessity for corrective actions are located in the "Updated Guidelines for Scoring, Corrective Action and Follow-up Monitoring." After all elements are assessed and scored, the LGE reviewer documents the findings, including the Statement of Determination which delineates every POC remediation required and required responses/plans of correction expected from the SCA. Based on the scope and severity of findings, the SCA is assigned a Statement of Determination at Level I, Level II, or Level III. The LGE and/or State Office follow-up according to timelines associated with each level to ensure that plans of correction are implemented and effective. Level III determinations are those having the actual or potential for immediate jeopardy. In these cases, the SCA must develop a plan of correction that includes the identification of the problem; full description of the underlying causes of the problem; actions/interventions that target each underlying cause; responsibility, timetable, and resources required to implement interventions; measurable indicators for assessing performance; and plans for monitoring desired progress and reporting results. In addition, OCDD takes enforcement action to assure the health and safety of participants. Actions include, but are not limited to: transfer of participants who are/may be in jeopardy; removal of SCA agency from the freedom of choice list; suspension of all new admissions; financial penalties; suspension of contract/certifications as a provider of SC services.
If a Plan of Correction, Progress Report and/or Follow-up Report remains unapproved by the time of the next annual review the agency placed on the next level with more stringent requirements. With a finding of satisfactory or a recommendation for improvement no remediation is required. These remediation activities will be documented through tracking events in the Support Coordination Monitoring database.
Training will be necessary when trends are detected in plans of care that do not address: participant goals, needs (including health care needs), and preferences; how waiver and other services are coordinated; and identification of responsibilities to implement the plan. The training requirements depend on the Support Coordination Monitoring findings and are based on the criteria found in OCDD Interpretive Guidelines for the OCDD Participant Record Review with a parallel set of guidelines entitled "Guidelines for Support Planning" for support coordinators.
An unsatisfactory plan of care is one with criteria "not met" according to the OCDD Interpretive Guidelines for the OCDD Participant Record Review and parallel set of guidelines entitled "Guidelines for Support Planning" for support coordinators.

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:

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*

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

- (●) **No**
- ( ) **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

In the 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 QIS* 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.

The state of Louisiana utilizes a collaborative approach to develop and maintain the Quality Improvement System (QIS). The Medicaid agency in Louisiana, Bureau of Health Services Financing Medicaid Program Support and Waivers (BHSF/MPSW) has oversight for the implementation of Home and Community Based Services (HCBS) Waivers. The Office for Citizens with Developmental Disabilities (OCDD) is the operating agency, and the local operating arm for HCBS Waivers is the Local Governing Entity (LGE). The LGE provides oversight and monitoring of the contracted support coordination agencies; the contracted support coordination agencies provide oversight and monitoring of service utilization. All of the above mentioned entities also work collaboratively with Louisiana protective services agencies, Health Standards Section (HSS) and/or law enforcement as deemed necessary. The process of trending, prioritizing and implementing system improvement activities are required on all levels with upward reporting to the operating agency for oversight and management of the Quality Improvement System including a summary of root cause analysis completed at each level and recommendations for design changes or other system improvements. This approach provides opportunities for continued communication and review of performance measures, discovery and remediation activities.
The Quality Improvement System (QIS) for the New Opportunities Waiver is part of a cross-waiver function of the Office of Aging and Adult Services (OAAS) and the Office for Citizens with Developmental Disabilities (OCDD). 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.
The QIS assures a consistent and high standard of quality across waiver programs through:
• Adoption of common standards and performance measures against which waiver programs are evaluated.
• Development of policies, tools, practices, training, protocols, contracts and agreements that embody sound approaches to managing, delivering and assessing HCBS services and supports. To the extent possible, HCBS waiver policies and practices have shared purposes, language and expectations.
• Streamlining and consolidation of functions to strengthen the collection and analysis of timely and reliable data on waiver performance.
• A transparent system of reporting performance data for use by program managers, policymakers, consumers, providers, and other stakeholders.
• A structured and coordinated process to identify improvement opportunities, set priorities, allocate resources, and implement effective strategies.
• A coordinated approach for evaluating the effectiveness of the QIS in meeting program goals.
OCDD has a multi-tiered system for quality improvement. Each level (Direct Service Provider Agency, Support Coordination Agency, Local Governing Entity, OCDD State Office, and BHSF) within the system is required to design and implement a Quality Management Strategy which is further described below.
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 LGE Processes:

The LGE is the operating arm for managing the New Opportunities Waiver (NOW), and they are also required to have a Quality Management Strategy. This entity represents the primary source for discovery and remediation information regarding the waiver. They are required to collect information on performance indicators, conduct remediation as needed, aggregate data and review to identify trends and patterns and areas in which improvement is needed, and prioritize needed improvements. They are required to design and implement quality enhancement strategies and evaluate the effectiveness of those strategies. Each LGE has a Quality Specialist whose function is to facilitate data analysis and review. Within each LGE, data review is conducted by programmatic and management staff and by the Regional Advisory Committee which is composed of stakeholders. OCDD State Office staff visit each LGE annually to validate the quarterly/annual data reported to State Office on performance indicators, to assure that remediation and system improvements occur as needed, and to provide technical assistance. When performance falls below the outlined measure, the LGE submits evidence to the operating agency, OCDD, with documentation of the quality improvement activities that have been implemented to improve performance. If the performance is not improved as outlined in the established benchmark, technical assistance will be provided to the LGE.

OCDD State Office Processes:

Aggregate data for waiver performance indicators are reviewed for trends and patterns on a quarterly basis by the OCDD Waiver Section (program personnel) and Quality Section. These groups review data to ensure remediation is being completed by the LGE and to analyze the data for systemic concerns across waivers and across LGEs. Upon completion of the analysis, a representative from these teams presents data to the OCDD Performance Review Committee, with recommendations for system improvement. The OCDD Performance Review Committee is composed of designated members from each of the OCDD sections: Quality, Business Analytics, Clinical, Waiver, Early Intervention, and other members as designated by the OCDD Executive Management Staff. This provides the committee with expertise from several disciplines when reviewing recommendations. It also affords OCDD the opportunity to utilize existing expertise, processes, and tools to address new concerns, recommend strategies, and recommend systemic improvement that is best practice to ensure quality improvement and success. These recommendations are presented to OCDD Executive Management for consideration and approval. When significant system changes are proposed, the OCDD Core Stakeholder Group is convened and given the opportunity to review the proposed systemic changes and provide input regarding the recommendations. . The Core Stakeholder Group is comprised of waiver participants, families of waiver participants, advocacy groups, including the state DD Council, and a representative from the Governor's office, and meets as needed based on system improvement activities. Recommendations, performance indicator data reports, and quality improvement initiatives status reports are also submitted to the Bureau of Health Services Financing (BHSF) on a quarterly basis.

BHSF/MPSW Processes:

Medicaid/Program Offices Quarterly Meeting – This group convenes at least quarterly to perform executive level oversight of the performance of HCBS waivers, assure their effectiveness and efficiency, and discuss any other programmatic issues common to the program offices and Medicaid. Goals are to act upon issues and recommendations received from the Medicaid HCBS Oversight Committee and other HCBS workgroups. This meeting is a forum for executive level problem resolution, planning, and development of quality redesign strategies. Members include representatives from MPSW, the Medicaid Director or Deputy Director, the OCDD Assistant Secretary or Deputy Assistant Secretary, and other designated staff.

Medicaid HCBS Oversight Committee – meets at least quarterly with the specific purpose to ensure proper oversight of the OAAS and OCDD operated HCBS Medicaid programs. Goals are to review current performance reports, determine need for new activities concerning quality and oversight in waiver programs, and ensure adequate remediation enforcement. Quality recommendations or issues which cannot be resolved at this level are placed on the agenda of the Medicaid/Program Offices Quarterly Meeting. Oversight members include HCBS quality management staff from MPSW and OCDD and are chaired by the MPSW Section Chief or designee. The committee meets at least quarterly with the following standing agenda items:

-OCDD operating agency staff present their analysis of all performance measure findings, remediation activities, and systemic improvements to MPSW as defined in the 1915© waiver quality strategy

-MPSW Section Chief or designee indicates approval or disapproval of quarterly/annual data and activities;

-Based on evidence presented, MPSW staff provides technical assistance, guidance, and support to the operating agency staff;

-MPSW performs administrative oversight functions for OCDD HCBS program.
MPSW/OCDD/HCBS Data Contractor Meetings – facilitates monthly meetings with OCDD and Medicaid data contractor to discuss waiver issues, problems, and situations which have arisen and do not comport with program policy. At these meetings, solutions are formulated, corrective actions are agreed upon, and follow-up implemented by OCDD as necessary in the form of internal policy or provider policy.
Ad Hoc Cross-Population HCBS Oversight Meetings – Additional meetings will be held jointly between MPSW, OCDD, and the Office of Aging and Adult Services (OAAS) on an as needed basis for the following purposes:
-Collaborate on design and implementation of a robust system of cross-population continuous quality improvement
-Present Quality Improvement Projects (QIP)
-Share ongoing communication of what works, doesn't work, and best practices.

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: Medicaid HCBS Oversight Committee	☐ **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 Waiver and Quality program staff, as well as 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. At this point, the Core Stakeholder Group may be convened, if needed, to address if system improvement has resulted from the system design/improvement activities.
BHSF/MPSW Processes:
Medicaid HCBS Oversight Committee – meets at least quarterly with the specific purpose to ensure proper oversight of the OAAS and OCDD operated HCBS Medicaid programs. Goals are to review current performance reports, determine need for new activities concerning quality and oversight in waiver programs, and ensure adequate remediation enforcement. Quality recommendations or issues which cannot be resolved at this level are placed on the agenda of the Medicaid/Program Offices Quarterly Meeting. Oversight members include HCBS quality management staff from MPSW and OCDD and the committee is chaired by the MPSW Section Chief or designee. The committee meets at least quarterly with the following standing agenda items:
-OCDD operating agency staff present their analysis of all performance measure findings, remediation activities, and systemic improvements to MPSW as defined in the 1915© waiver quality strategy
-MPSW Section Chief or designee indicates approval or disapproval of quarterly/annual data and activities;
-Based on evidence presented, MPSW staff provides technical assistance, guidance, and support to the operating agency staff;
-MPSW performs administrative oversight functions for OCDD HCBS program.

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

The Medicaid Program Support and Waivers Section works in collaboration with the operating agency, OCDD, to periodically review the quality improvement strategies. Meetings are held to review and evaluate the performance indicators, discovery methods, remediation strategies, systemic issues, policies, procedures and any other issues that have surfaced as a result monitoring activities. Technical assistance is provided to the operating agency as needed by Bureau of Health Services Financing Medicaid Program Support and Waivers (BHSF/MPSW).
The operating agency, OCDD, has a Performance Review Committee which meets at least quarterly and provides ongoing oversight and management of the Quality Improvement System.
OCDD participates in the annual National Core Indicator (NCI) surveys which are addressed to a random sample of participants and families of participants to gauge their satisfaction with OCDD waiver services, and with the performance of support coordinators, LGEs and providers. OCDD aggregates findings to identify areas of concern in service delivery in order to initiate quality improvement strategies.
Findings from this annual review will be analyzed by the Performance Review Committee to revise the QIS. Modifications may be made to quality standards and measures, data collection tools and methods, report formats documenting performance, or dissemination strategies for sharing performance data. New priority projects may be identified to better align the QIS to the needs of waiver managers, LGE program staff, support coordinators and providers and, most significantly, to improve desired outcomes for HCBS waiver participants. The modifications and priorities identified by the Performance Review Committee will be implemented or facilitated by the OCDD Quality Enhancement Section.

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).

Program Integrity's Surveillance and Utilization Review (SUR) Unit is responsible for conducting post-payment reviews of all fee-for-service Medicaid 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 complaints and data mining, individual cases are opened and investigated or Self-Audit notices are sent out to providers. Random audits are also performed.

Once a given provider is chosen for audit, the case is referred to professional staff (which may include RN, Dentists, medical doctors etc.,) for review. A claims history and scientific sample are generated, producing a list of participants for detailed review. Medical records as well as other pertinent records are obtained from the given provider. Records are generally obtained from providers via unannounced on-site visits.

Once records are obtained, the SUR staff will thoroughly review the records for billing anomalies, policy compliance, and proper documentation. When overpayments are detected, overpayments 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.

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 and does not follow a set frequency sequence.

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 and does not follow a set frequency sequence.

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.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

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

i. Sub-Assurances:

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
I.a.i.a.1. Number and percent of services that are in compliance with the approved rate methodology. Numerator= Number of services that are in compliance with the approved rate methodology. Deominator=Total number of services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MPSW Tracking 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:	☐ **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:

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

Performance Measures

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

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

Performance Measure:

I.a.i.b.1. Number and percentage of waiver claims submitted which did not exceed the approved rate. Numerator= Number of submitted waiver claims which did not exceed the approved rate Denominator= Total number of paid claims.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Data Warehouse

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ Continuously and Ongoing
	☐ Other Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
I.a.i.a.1. BHSF determines all waiver payment amounts/rates in collaboration with OCDD, Division of Health Economics, and as necessary the Rate & Audit section. At the time of each requested rate change, MPSW and the Rate and Audit section reviews evidence that the rate adjustment was applied according to the methodology described in the waiver document. When a rate adjustment proposal is submitted without documentation which supports the current methodology it will not be approved and MPSW will offer technical guidence.
I.a.i.b.1 Upon annual review and analysis of all waiver claims payments through Medicaid Data Warehouse report generation, any discrepancies are resolved individually and systmically in collaboration with Medicaid Information Management Systems staff who oversee the Fiscal Intermediary.

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, and the parties responsible for its operation.

Appendix I: Financial Accountability

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

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

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

Rates for each service is based on following for each service:

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

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

Professional Services and Skilled Nursing rates were established by looking at the rate of similar services provided under the Medicaid State Plan. For state plan look-a-like services, the rate of the similar service under the state plan was used (i.e. RN, LPN, CNA services). For all other professional services, the rate was negotiated based upon the provider cost of rendering the service balanced against the potential cost of waiver and the availability of state funding.

Supported Employment, Day Habilitation, and Prevocational Services rates were established by using the Louisiana Rehabilitative Services rate for employment services. The rates for Day Habilitation were negotiated between providers and DHH based on provider cost of providing the service and availability of state funding.

Personal Emergency Response System rates are based on the actual cost of providing the service.

Community Living Adaptations, Equipment, and Supplies, and One Time Transitional Services are paid at the cost

of the provision of services with each having a annual cap. This cap was set based on the historical cost of providing the service.

Substitute Family Care and Supported Living rates are the result of negotiations between the advocates, stakeholders, and waiver personnel based on provider cost of providing the service, historical utilization trends, and state funds available.

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

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

All proposed rates are then plugged 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. Participants may also receive information on service rates by contacting their Regional OCDD Waiver Services and Supports Office.

b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

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

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

Appendix I: Financial Accountability

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

c. **Certifying Public Expenditures** *(select one)*:

◉ **No. State or local government agencies do not certify expenditures for waiver services.**

○ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how

the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

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

d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The Bureau of 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 IFS service. 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.

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ( ) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- (●) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

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 NOW waiver participants and will be paid for those services. Those NOW services will include transitional support services, individual and family services, and residential habilitation services supported employment, employment related training, and day habilitation. These waiver services delivered by the Regional Service Centers are not located in institutional-based settings.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how

the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

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

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

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

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

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

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

◉ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

○ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

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

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

◉ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

○ **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

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

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

Appendix I: Financial Accountability

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

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

☑ **Appropriation of State Tax Revenues to the State Medicaid agency**

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

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

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

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

Appendix I: Financial Accountability

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

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

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

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

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

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

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

Appendix I: Financial Accountability

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

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

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

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

Appendix I: Financial Accountability

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

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

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

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

Appendix I: Financial Accountability

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

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

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

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

Appendix I: Financial Accountability

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

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

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

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

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- ◉ **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ○ **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	51950.56	7762.00	59712.56	76036.00	7083.00	83119.00	23406.44
2	51915.64	8034.00	59949.64	76036.00	7331.00	83367.00	23417.36
3	51940.24	8315.00	60255.24	76036.00	7587.00	83623.00	23367.76
4	53387.90	8606.00	61993.90	76036.00	7853.00	83889.00	21895.10
5	51919.81	8907.00	60826.81	76036.00	8128.00	84164.00	23337.19

Appendix J: Cost Neutrality Demonstration

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

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

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)		
		Level of Care:		
		ICF/IID		
Year 1	8900		8900	
Year 2	8950		8950	
Year 3	9000		9000	
Year 4	9050		9050	
Year 5	9100		9100	

Appendix J: Cost Neutrality Demonstration

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

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

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

Appendix J: Cost Neutrality Demonstration

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

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

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

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

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

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

To exclude Medicare Part D Pharmacy cost from our cost effectiveness calculations we:
1. identified all NOW recipients who had dual eligibility for Medicaid and Medicare services
2. developed an independent query to identify pharmacy related Part D acute care expenditures.
3. based on these expenditures, an estimate for average annual Part D expenditure per recipient was derived.
4.deducted this amount from the average acute care cost per waiver recipient.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

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

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

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

To exclude Medicare Part D Pharmacy cost from our cost effectiveness calculations we:
1. identified all ICF/DD recipients who had dual eligibility for Medicaid and Medicare services
2. developed an independent query to identify pharmacy related Part D acute care expenditures.
3. based on these expenditures, an estimate for average annual Part D expenditure per recipient was derived.
4. deducted this amount from the average acute care cost per ICF/DD recipient.

Appendix J: Cost Neutrality Demonstration

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

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

Waiver Services	
Center-Based Respite	
Day Habilitation	
Individual and Family Support	
Prevocational Services	
Supported Independent Living	
Supported Employment	
Skilled Nursing	
Specialized Medical Equipment and Supplies	
Adult Companion Care	
Community Integration and Development	
Environmental Accessibility Adaptations	
Housing Stabilization Service	
Housing Stabilization Transition Service	
One-Time Transitional	
Personal Emergency Response	
Professional Services	
Substitute Family Care (SFC)	

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
Center-Based Respite Total:						**828474.90**
Center-Based Respite	15 minutes	165	1574.00	3.19	828474.90	
Day Habilitation Total:						**11231900.16**
Day Habilitation	15 minutes	1824	3224.00	1.91	11231900.16	
Individual and Family Support Total:						**379161040.00**
Individual and Family Support	15 minutes	8509	13925.00	3.20	379161040.00	
Prevocational Services Total:						**4571842.52**
			GRAND TOTAL:			**462360026.31**
			Total Estimated Unduplicated Participants:			**8900**
			Factor D (Divide total by number of participants):			**51950.56**
			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	15 minutes	889	3098.00	1.66	4571842.52	
Supported Independent Living Total:						12306965.04
Supported Independent Living	daily	2377	306.00	16.92	12306965.04	
Supported Employment Total:						40433798.16
Supported Employment	15 minutes	1064	2619.00	14.51	40433798.16	
Skilled Nursing Total:						11435459.70
Skilled Nursing	15 minutes	133	10995.00	7.82	11435459.70	
Specialized Medical Equipment and Supplies Total:						36139.35
Specialized Medical Equipment and Supplies	annually	65	1.00	555.99	36139.35	
Adult Companion Care Total:						838040.00
Adult Companion Care	daily	56	365.00	41.00	838040.00	
Community Integration and Development Total:						7149.60
Community Integration and Development	15 minutes	9	240.00	3.31	7149.60	
Environmental Accessibility Adaptations Total:						1236873.60
Environmental Accessibility Adaptations	annually	240	3.00	1717.88	1236873.60	
Housing Stabilization Service Total:						182.05
Housing Stabilization Service	15 min	5	11.00	3.31	182.05	
Housing Stabilization Transition Service Total:						182.05
Housing Stabilization Transition Service	15 min	5	11.00	3.31	182.05	
One-Time Transitional Total:						30648.00
One-Time Transitional	1 time	12	1.00	2554.00	30648.00	
Personal Emergency Response Total:						170667.42
Personal Emergency Response	monthly	574	11.00	27.03	170667.42	
Professional Services Total:						62002.98
				GRAND TOTAL:		462360026.31
				Total Estimated Unduplicated Participants:		8900
				Factor D (Divide total by number of participants):		51950.56
				Average Length of Stay on the Waiver:		356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Psychologist	15 minutes	149	14.00	29.55	61641.30	
Social Worker	15 minutes	3	8.00	9.19	220.56	
Nutrition/Dietary Services	15 minutes	2	8.00	8.82	141.12	
Substitute Family Care (SFC) Total:						8660.78
Substitute Family Care (SFC)	daily	2	229.00	18.91	8660.78	
				GRAND TOTAL:		462360026.31
				Total Estimated Unduplicated Participants:		8900
				Factor D (Divide total by number of participants):		51950.56
				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
Center-Based Respite Total:						828474.90
Center-Based Respite	15 minutes	165	1574.00	3.19	828474.90	
Day Habilitation Total:						11231900.16
Day Habilitation	15 minutes	1824	3224.00	1.91	11231900.16	
Individual and Family Support Total:						381032560.00
Individual and Family Support	15 minutes	8551	13925.00	3.20	381032560.00	
Prevocational Services Total:						4597555.92
Prevocational Services	15 minutes	894	3098.00	1.66	4597555.92	
Supported Independent Living Total:						12374272.80
Supported Independent Living	daily	2390	306.00	16.92	12374272.80	
				GRAND TOTAL:		464645017.84
				Total Estimated Unduplicated Participants:		8950
				Factor D (Divide total by number of participants):		51915.64
				Average Length of Stay on the Waiver:		356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment Total:						**40661808.30**
Supported Employment	15 minutes	1070	2619.00	14.51	**40661808.30**	
Skilled Nursing Total:						**11521440.60**
Skilled Nursing	15 minutes	134	10995.00	7.82	**11521440.60**	
Specialized Medical Equipment and Supplies Total:						**36139.35**
Specialized Medical Equipment and Supplies	annually	65	1.00	555.99	**36139.35**	
Adult Companion Care Total:						**838040.00**
Adult Companion Care	per diem	56	365.00	41.00	**838040.00**	
Community Integration and Development Total:						**7149.60**
Community Integration and Development	15 minutes	9	240.00	3.31	**7149.60**	
Environmental Accessibility Adaptations Total:						**1242027.24**
Environmental Accessibility Adaptations	annually	241	3.00	1717.88	**1242027.24**	
Housing Stabilization Service Total:						**182.05**
Housing Stabilization Service	15 min	5	11.00	3.31	**182.05**	
Housing Stabilization Transition Service Total:						**182.05**
Housing Stabilization Transition Service	15 min	5	11.00	3.31	**182.05**	
One-Time Transitional Total:						**30648.00**
One-Time Transitional	1 time	12	1.00	2554.00	**30648.00**	
Personal Emergency Response Total:						**171559.41**
Personal Emergency Response	monthly	577	11.00	27.03	**171559.41**	
Professional Services Total:						**62416.68**
Psychologist	15 minutes	150	14.00	29.55	**62055.00**	
Social Worker	15 minutes	3	8.00	9.19	**220.56**	
Nutrition/Dietary Services	15 minutes	2	8.00	8.82	**141.12**	
				GRAND TOTAL:		**464645017.84**
				Total Estimated Unduplicated Participants:		**8950**
				Factor D (Divide total by number of participants):		**51915.64**
				Average Length of Stay on the Waiver:		356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Substitute Family Care (SFC) Total:						**8660.78**
Substitute Family Care (SFC)	daily	2	229.00	18.91	**8660.78**	
				GRAND TOTAL:		**464645017.84**
				Total Estimated Unduplicated Participants:		**8950**
				Factor D (Divide total by number of participants):		**51915.64**
				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
Center-Based Respite Total:						**833495.96**
Center-Based Respite	15 minutes	166	1574.00	3.19	**833495.96**	
Day Habilitation Total:						**11231900.16**
Day Habilitation	15 minutes	1824	3224.00	1.91	**11231900.16**	
Individual and Family Support Total:						**383394240.00**
Individual and Family Support	15 minutes	8604	13925.00	3.20	**383394240.00**	
Prevocational Services Total:						**4623269.32**
Prevocational Services	15 minutes	899	3098.00	1.66	**4623269.32**	
Supported Independent Living Total:						**12446758.08**
Supported Independent Living	daily	2404	306.00	16.92	**12446758.08**	
Supported Employment Total:						**40889818.44**
Supported Employment	15 minutes	1076	2619.00	14.51	**40889818.44**	
Skilled Nursing Total:						**11607421.50**
Skilled Nursing	15 minutes				**11607421.50**	
				GRAND TOTAL:		**467462158.29**
				Total Estimated Unduplicated Participants:		**9000**
				Factor D (Divide total by number of participants):		**51940.24**
				Average Length of Stay on the Waiver:		356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		135	10995.00	7.82		
Specialized Medical Equipment and Supplies Total:						36695.34
Specialized Medical Equipment and Supplies	annually	66	1.00	555.99	36695.34	
Adult Companion Care Total:						838040.00
Adult Companion Care	per diem	56	365.00	41.00	838040.00	
Community Integration and Development Total:						7149.60
Community Integration and Development	15 minutes	9	240.00	3.31	7149.60	
Environmental Accessibility Adaptations Total:						1247180.88
Environmental Accessibility Adaptations	annually	242	3.00	1717.88	1247180.88	
Housing Stabilization Service Total:						182.05
Housing Stabilization Service	15 min	5	11.00	3.31	182.05	
Housing Stabilization Transition Service Total:						182.05
Housing Stabilization Transition Service	15 min	5	11.00	3.31	182.05	
One-Time Transitional Total:						30648.00
One-Time Transitional	1 time	12	1.00	2554.00	30648.00	
Personal Emergency Response Total:						172451.40
Personal Emergency Response	monthly	580	11.00	27.03	172451.40	
Professional Services Total:						94064.73
Psychologist	15 minutes	151	21.00	29.55	93703.05	
Social Worker	15 minutes	3	8.00	9.19	220.56	
Nutrition/Dietary Services	15 minutes	2	8.00	8.82	141.12	
Substitute Family Care (SFC) Total:						8660.78
Substitute Family Care (SFC)	daily	2	229.00	18.91	8660.78	
				GRAND TOTAL:		467462158.29
				Total Estimated Unduplicated Participants:		9000
				Factor D (Divide total by number of participants):		51940.24
				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
Center-Based Respite Total:						838517.02
Center-Based Respite	15 minutes	167	1574.00	3.19	838517.02	
Day Habilitation Total:						11231900.16
Day Habilitation	15 minutes	1824	3224.00	1.91	11231900.16	
Individual and Family Support Total:						398785821.00
Individual and Family Support	15 minutes	8652	13925.00	3.31	398785821.00	
Prevocational Services Total:						4648982.72
Prevocational Services	15 minutes	904	3098.00	1.66	4648982.72	
Supported Independent Living Total:						12514065.84
Supported Independent Living	daily	2417	306.00	16.92	12514065.84	
Supported Employment Total:						41117828.58
Supported Employment	15 minutes	1082	2619.00	14.51	41117828.58	
Skilled Nursing Total:						11607421.50
Skilled Nursing	15 minutes	135	10995.00	7.82	11607421.50	
Specialized Medical Equipment and Supplies Total:						36695.34
Specialized Medical Equipment and Supplies	annually	66	1.00	555.99	36695.34	
Adult Companion Care Total:						838040.00
Adult Companion Care	per diem	56	365.00	41.00	838040.00	
Community Integration and Development Total:						7149.60
					7149.60	
			GRAND TOTAL:			483160467.60
			Total Estimated Unduplicated Participants:			9050
			Factor D (Divide total by number of participants):			53387.90
			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 Integration and Development	15 minutes	9	240.00	3.31		
Environmental Accessibility Adaptations Total:						**1257488.16**
Environmental Accessibility Adaptations	annually	244	3.00	1717.88	**1257488.16**	
Housing Stabilization Service Total:						**182.05**
Housing Stabilization Service	15 min	5	11.00	3.31	**182.05**	
Housing Stabilization Transition Service Total:						**182.05**
Housing Stabilization Transition Service	15 min	5	11.00	3.31	**182.05**	
One-Time Transitional Total:						**30648.00**
One-Time Transitional	1 time	12	1.00	2554.00	**30648.00**	
Personal Emergency Response Total:						**173640.72**
Personal Emergency Response	monthly	584	11.00	27.03	**173640.72**	
Professional Services Total:						**63244.08**
Psychologist	15 minutes	152	14.00	29.55	**62882.40**	
Social Worker	15 minutes	3	8.00	9.19	**220.56**	
Nutrition/Dietary Services	15 minutes	2	8.00	8.82	**141.12**	
Substitute Family Care (SFC) Total:						**8660.78**
Substitute Family Care (SFC)	daily	2	229.00	18.91	**8660.78**	
				GRAND TOTAL:		**483160467.60**
				Total Estimated Unduplicated Participants:		**9050**
				Factor D (Divide total by number of participants):		**53387.90**
				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
Center-Based Respite Total:						843538.08
Center-Based Respite	15 minutes	168	1574.00	3.19	843538.08	
Day Habilitation Total:						11231900.16
Day Habilitation	15 minutes	1824	3224.00	1.91	11231900.16	
Individual and Family Support Total:						387672000.00
Individual and Family Support	15 minutes	8700	13925.00	3.20	387672000.00	
Prevocational Services Total:						4674696.12
Prevocational Services	15 minutes	909	3098.00	1.66	4674696.12	
Supported Independent Living Total:						12586551.12
Supported Independent Living	daily	2431	306.00	16.92	12586551.12	
Supported Employment Total:						41345838.72
Supported Employment	15 minutes	1088	2619.00	14.51	41345838.72	
Skilled Nursing Total:						11693402.40
Skilled Nursing	15 minutes	136	10995.00	7.82	11693402.40	
Specialized Medical Equipment and Supplies Total:						36695.34
Specialized Medical Equipment and Supplies	annually	66	1.00	555.99	36695.34	
Adult Companion Care Total:						838040.00
Adult Companion Care	per diem	56	365.00	41.00	838040.00	
Community Integration and Development Total:						7149.60
Community Integration and Development	15 minutes	9	240.00	3.31	7149.60	
Environmental Accessibility Adaptations Total:						1262641.80
Environmental Accessibility Adaptations	annually	245	3.00	1717.88	1262641.80	
Housing Stabilization Service Total:						172.15
Housing Stabilization Service	15 min	5	11.00	3.13	172.15	
				GRAND TOTAL:		472470296.91
				Total Estimated Unduplicated Participants:		9100
				Factor D (Divide total by number of participants):		51919.81
				Average Length of Stay on the Waiver:		356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Housing Stabilization Transition Service Total:						**172.15**
Housing Stabilization Transition Service	15 min	5	11.00	3.13	**172.15**	
One-Time Transitional Total:						**30648.00**
One-Time Transitional	1 time	12	1.00	2554.00	**30648.00**	
Personal Emergency Response Total:						**174532.71**
Personal Emergency Response	monthly	587	11.00	27.03	**174532.71**	
Professional Services Total:						**63657.78**
Psychologist	15 minutes	153	14.00	29.55	**63296.10**	
Social Worker	15 minutes	3	8.00	9.19	**220.56**	
Nutrition/Dietary Services	15 minutes	2	8.00	8.82	**141.12**	
Substitute Family Care (SFC) Total:						**8660.78**
Substitute Family Care (SFC)	daily	2	229.00	18.91	**8660.78**	
				GRAND TOTAL:		**472470296.91**
				Total Estimated Unduplicated Participants:		**9100**
				Factor D (Divide total by number of participants):		**51919.81**
				Average Length of Stay on the Waiver:		356