Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Plan of Care

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- ☐ **Social Worker**

Specify qualifications:

- ☐ **Other**

Specify the individuals and their qualifications:

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

b. **Service Plan Development Safeguards.** *Select one:*

- ◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

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

• Following selection of and linkage to a Support Coordinator agency, the assigned Support Soordinator explains all available services in the waiver during the initial contact so that the participant and his/her family/legal representatives can make informed choices. The participant is also informed of any procedural safeguards, their

rights and responsibilities, how to request a change of Support Coordination agencies or Direct Service Providers, and the grievance and/or complaint procedures. Printed information is given to the participant at this visit. The Support Coordinator provides assistance in gaining access to the full range of needed services including medical, social, educational, and/or other supports as identified by the participant.

• The initial planning meetings are conducted in a face-to-face visit in the participant's place of residence. During the initial visit, the participant chooses who will be part of his/her planning process. The Support Coordinator assists the participant/family in contacting the team members with the date(s) and time(s) of meeting(s). The Support Coordinator facilitates the planning meeting with the participant/family driving the planning process.

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d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

A. PLAN OF CARE (POC) DEVELOPMENT AND TIMING

Linkage to support coordination through certification for waiver services takes up to 90 days. During the 90 day period, the following activities occur:

•Initial support coordinator (SC) contact with the participant
•The support coordinator contacts the family to arrange a face-to-face meeting at a location convenient to the family.
•The support coordinator will schedule a time to assess the participant's needs utilizing the SIS/LAPLUS. This assessment, along with a person-centered planning process will be utilized to determine which OCDD waiver is offered
•The POC is developed through a collaborative support team process involving the participant, family, and support team.
•The approvable POC must be approved within 90 days after linkage. An exception to this timeline will be made if the participant files an appeal as to the results of the SIS/LA Plus assessments which determines the OCDD Waiver offered, or if housing cannot be secured with a reasonable time period.
•The LGE staff have ten working days in which to review the POC information, complete the precertification home visit and approve the POC prior to waiver services beginning. If Medicaid eligibility is delayed, then the LGE has 5 days from the date of receipt of the Medicaid eligibility determination to approve the POC. Waiver services cannot begin prior to the approved POC.
•The entire team meets annually or as needed to review and revise the POC for the upcoming service year.

B. INITIAL ASSESSMENTS

The Office for Citizens with Developmental Disabilities (OCDD) has developed the "Guidelines for Support Planning" as a framework for all activities related to planning for individualized supports and services. The needs-based assessments described below are completed within the discovery process for all applicants who have received an OCDD waiver offer and to identify the individual's service needs.

Discovery activities include:
1. A review of the participant's records relevant to service planning (i.e. school, vocational, medical, and psychological records).

2. Conducting a personal outcomes assessment, which assists the planning team in determining what is important to the participant and his/her satisfaction or dissatisfaction with different life domain areas.

3. The completion and review of the Supports Intensity Scale (SIS) and Louisiana PLUS (LA PLUS) assessments are done within 30 days of linkage.

a. The Supports Intensity Scale (SIS) is a standardized assessment tool designed to evaluate the practical support requirements of people with developmental disabilities. The SIS measures support needs for 85 different activities in the areas of home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy. The SIS then rates each activity according to frequency, amount, and type of supports needed.

b. The Louisiana PLUS (LA PLUS) is a complimentary assessment tool designed to identify support needs and related information not addressed by the SIS. The LA PLUS is used to evaluate a person's support needs based on information and data collected from four areas of the person's life, including:

i. Other support needs; material supports; hearing-related supports; supports for communicating needs; and stress and risks factors.
ii. Living arrangements
iii. Medical and diagnostic information
iv. Personal satisfaction reports; supports at home; work/day programs; living environment; family relationships; and social relationships.

4. A review and/or completion of any additional interviews, observations, or other needed professional assessments (i.e. occupational therapist, physical therapist, or speech therapist assessments). Information obtained through the discovery process is shared with the support team in preparation for the POC meeting. Discovery activities are summarized and conclude with the POC meeting. Based on the findings of the discovery activities described above a POC is developed.

C. PLAN OF CARE (POC) DEVELOPMENT AND TIMING

• For individuals offered a Residential Options Waiver, an Inventory for Client and Agency Planning (ICAP) is completed initially and is required prior to developing the final Plan of Care submitted for approval.

•• The Plan of Care is developed through a collaborative process which includes the Support Coordinator, participant and his/her family and friends, legal representatives, appropriate professionals/service providers, and others whom the participant chooses to be involved. This group is hereafter referred to as the support team.

•• Initial Support Coordinator contact with the participant occurs within 3 business days of being linked to the Support Coordination agency of choice.

•• For initial participants, the Plan of Care development process must begin within seven (7) calendar days following linkage to the Support Coordination agency of the participant's choice.

• The support coordinator contacts the family to arrange a face-to-face meeting within 10 days of linkage at a time and location convenient to the family.

• The Support Coordinator will schedule a time to assess the participant's needs utilizing the SIS/LA PLUS within 30 days of linkage. This assessment, along with a person centered planning process will be utilized to determine which OCDD waiver is offered.

• The Support Coordinator is required to submit the complete initial Plan of Care to the appropriate LGE within sixty (60) days following linkage. An exception to this timeline will be made if the participants files an appeal as to the results of the SIS/LA Plus assessment(s) and person centered planning process which determines the OCDD Waiver offered, or if housing cannot be secured within a reasonable time.

• The LGE staff has ten (10) business days to review the information, complete the precertification home visit and approve the Plan of Care prior to waiver services beginning. If Medicaid eligibility is delayed, then the LGE has 5 days from the date of receipt of the Medicaid eligibility determination to approve the POC. Waiver services cannot begin prior to the approved POC.

• At least quarterly, the Support Coordinator and the participant/family, and others the participant/family chooses to be present, review the Plan of Care to determine if the goals identified in the Plan of Care are being achieved, if the participant's/family's needs including health and welfare are being addressed, and to make any adjustments or changes to the Plan of Care as necessary.

•• The entire support team meets annually to review and revise the participant's Plan of Care for the new Plan of Care year. The annual date of the Plan of Care does not change, even if there has been a more recent meeting to revise the services within the Plan of Care. Updated annual plans of care must be submitted to the Support Coordination Supervisor/LGE as defined by OCDD policy at least 35 days prior to plan expiration.

D. ROW LEVEL ASSESSMENTS

The Developmental Disabilities Support Needs Assessment Profile (DD SNAP) and the Inventory for Client and Agency Planning (ICAP) are completed for all applicants to the Louisiana developmental disability system. As appropriate other standardized assessments ((i.e., test of intellectual functioning (Wechsler Series of Intelligence Test and Stanford-Binet Intelligence Scales) and test of adaptive functioning (Vineland Adaptive Behavior Scales)) are used during the systems entry process to determine if an applicant has an intellectual or developmental disability. Information from the above assessments, as appropriate, is used in the development of the Plan of Care.

The needs-based assessments described below are completed within the discovery process for all applicants to identify the individual's service needs. Discovery activities include:

•• An ICAP which is completed initially and as needed and is required prior to developing the Plan of Care.
•• A review of the participant's records relevant to service planning (i.e. school, vocational, medical, psychological records, etc.)
•• A personal outcomes assessment, which assists the planning team in determining personal goals and desired personal outcomes
•• A review and/or completion of any additional interviews, observations, or other needed professional assessments (i.e. occupational therapy, physical therapy, speech therapy, nutritional, etc.)

In addition, the needs-based assessments described below may be completed within the discovery process for all applicants to provide additional information to assist in identifying the individual's service needs. Discovery activities may include the completion and review of the Supports Intensity Scale (SIS) and Louisiana PLUS (LA PLUS) assessments.

•• The Supports Intensity Scale (SIS) is a standardized assessment tool designed to evaluate the practical support requirements of people with developmental disabilities. The SIS measures support needs for 85 different activities in the areas of home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy. The SIS then rates each activity according to frequency, amount, and type of supports needed.

•• The Louisiana PLUS (LA PLUS) is a complimentary assessment tool designed to identify support needs and related information not addressed by the SIS. The LA PLUS is used to evaluate a person's support needs based on information and data collected from four areas of the person's life, including:
- o Other support needs – material supports; hearing-related supports; supports for communicating needs; and stress and risks factors.
- o Living arrangements
- o Medical and diagnostic information
- o Personal satisfaction reports – supports at home; work/day programs; living environment; family relationships; and social relationships.

Information obtained through the discovery process is shared with the support team in preparation for the Plan of Care meeting and result in an individualized Plan of Care.

Based on the findings of the discovery activities described above a Plan of Care is developed.

A reassessment may be conducted at any time, particularly with a significant life change, but must be completed at least annually. The assessment process is intended to be ongoing and designed to reflect changes in the participant's life, needs, and personal outcomes, inclusive of his/her preferences.

If the participant disagrees with the proposed services in the Plan of Care the participant or his/her family/authorized representative may request additional services and present supporting documentation. If the participant or his/her family/authorized representative is not satisfied with the decision related to the request for additional services, then he/she may appeal any limit or denial of services through the Louisiana Department of Health, Bureau of Appeals' process as referenced in Appendix F-1, Opportunity to Request a Fair Hearing.

E. HOW PARTICIPANTS ARE INFORMED OF AVAILABLE SERVICES

The Support Coordinator informs the participant and his/her family/authorized representative of all available waiver services during the initial contact with the Support Coordination agency, in quarterly meetings as needed, on an annual basis during the Plan of Care development process, and as requested.

F. INCORPORATION OF PARTICIPANT GOALS/NEEDS/PREFERENCES IN THE PLAN OF CARE

The following components are designed to incorporate the participant's goals, needs, and preferences in the Plan of Care:

• Discovery, which involves gathering information about the participant's interests, goals, preferences, and support needs through assessments and interviews. The discovery process ends with the formulation of the participant's vision and goals.

• Planning. This involves using the information from the discovery process to develop the Plan of Care. During the planning process, the support team works with the participant to develop strategies to assist him/her in achieving his/her goals and support needs. Strategies should identify all supports needed to assist the participant in achieving his/her goals and meeting other identified support needs and an appropriate action plan. For each personal outcome/goal identified, the support team will identify the following: the participant's strengths, skills, abilities that can be used to achieve his/her goals; challenges, barriers, health issues, or risk factors that can be deterrents to meeting his/her goals; strategies, treatments, or trainings which can be implemented to overcome barriers; any opportunities available for increasing the participant's independence in achieving his/her goals.

• Implementation, which involves the completion of noted strategies and provision of needed supports according to the participant's Plan of Care.

G. COORDINATION OF SERVICES

The planning process requires the identification and utilization of all appropriate supports available to the participant prior to the support team considering waiver services.

Services are coordinated through the participant's Support Coordinator. The Support Coordinator leads the support team in developing a Plan of Care with and for the participant. The Plan of Care must include the following required components:

•• The participant's prioritized personal goals and specific strategies to achieve or maintain his/her desired personal goals. These strategies will focus first on the natural and community supports available to the participant and, if needed, paid services will be accessed as a supplement to natural and community supports.
•• An action plan which will lead to the implementation of strategies to achieve the participant's personal goals, including action steps, review dates, and the names of the persons who are responsible for specific steps.
• Identified barriers, including health and safety risks, and specific strategies with timelines and the persons assigned to specific responsibilities, to address each issue.
• All the services and supports the participant receives, regardless of the funding source which may include natural support networks, generic community services, and state plan services.
• Identification of the frequency and location of services through a daily and alternate schedule.
• Identification of providers and specification of the service arrangement.
• Identification of the support team members who will assist the support coordinator in the planning process, as well as building and implementing supports for the participant.
•• Signature of all support team members present in the planning meeting to indicate their agreement with the Plan of Care.

H. ASSIGNMENT OF RESPONSIBILITIES TO IMPLEMENT AND MONITOR PLAN OF CARE

Each participant's Plan of Care includes multiple strategies and actions to achieve his/her life vision and goals, while addressing key support needs. The support team is responsible for:

- Identifying any necessary training the participant's family or staff need in order to implement the actions and strategies described in the Plan of Care and determining who will provide the necessary training.

- Identifying any resources needed by the participant's family or staff to implement the actions and strategies described in the Plan of Care and determining who will provide or acquire the needed resources.

In addition, the Support Coordinator is required to make a monthly contact with participant as well as visit the participant in his/her home once per quarter to monitor the implementation of the Plan of Care, the participant's satisfaction with services, and to determine if the participant has any new interests, goals, or needs.

The Support Coordinator is responsible for reviewing the information on the Plan of Care, tracking progress on identified goals and timelines, and obtaining updated information on the participant's natural supports. This includes monitoring how individual providers (e.g. vocational, supported living) implement their portion of the participant's Plan of Care so that all relative goals and objectives are achieved.

During the quarterly monitoring reviews, the support team will review various data sources related to the participant's goals and objectives in order to determine if progress has been made.

OCDD uses the Guidelines for Support Planning, Chapter 9, Review and Modification of the Participant's Support Plan for HOW AND WHEN PLAN IS UPDATED.
http://dhh.louisiana.gov/assets/docs/OCDD/waiver/NOW/Guidelines_Support_Planning.pdf

I. HOW AND WHEN PLAN IS UPDATED

At least quarterly, the support team meets to review the Plan of Care to determine if the participant's goals have been achieved, if the participant's needs are being met, and to make any adjustments to the Plan of Care.

The Plan of Care must be updated at least annually or as necessary to meet the participant's needs. To be considered timely, the plan of care must be approved prior to the expiration of the previous plan of care.

At any time that the Support Coordinator or any other support team member identifies a condition related to the participant's health status, behavioral change, or any other type of change which is not satisfactorily addressed or which requires updated discussion or planning, the support coordinator will immediately reconvene the support team to revise the Plan of Care to reflect the participant's revised needs and desired outcomes. This change in the participant's condition or health status, behavior or other change may or may not have been identified through re-assessment of the ICAP but may have recently surfaced, been identified through the participant's primary care physician, or been identified through periodic monitoring.

Emergency revisions must be submitted by the support coordinator to the Support Coordination Supervisor/LGE as defined in OCDD policy within twenty-four (24) hours or by the next working day for approval. Revisions that include routine changes, such as planned vacations, must be submitted by the Support Coordinator at least seven (7) days prior to the change.

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D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Information from various assessments conducted during the planning process is used to identify any potential risks, which are then addressed through mitigation strategies that are included in the Plan of Care.

In addition, information gained during interviews with the participant and his/her legal representatives and support team members, as well as information from the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District pre-certification visit is also used during the initial planning process to identify potential risks to the participant.

•• The participant and all support team members are given informed choice regarding the inclusion of any strategies recommended to be included in an initial or revised Plan of Care. The initial or revised Plan of Care with the included strategies must be signed and dated by all support team members.

•• Recommendations from support team members on strategies to mitigate specific risk are incorporated into the Plan of Care. The LGE reviews recommendations, makes additional recommendations, and/or refers the issue to the OCDD State Office for input prior to approval of an initial or revised Plan of care.

• The direct service provider is responsible for completing an emergency evacuation plan and back- up plan for each participant. Both are submitted to the Support Coordinator during the Plan of Care development process. The Support Coordinator is responsible for submitting the back-up plan and emergency evacuation plan to the LGE or Support Coordination Supervisor along with the participant's Plan of Care. The LGE or Support Coordination Supervisor ensures that the back- up plan and emergency evacuation plan are in place and will not approve the Plan of Care without these documents.

BACK-UP STAFFING PLANS

• Support Coordinators are to ensure that back-up and emergency evacuation plans are in place.

• All enrolled providers of waiver services must possess the capacity to provide the support and services required by the participant in order to insure the participant's health and safety as outlined in the Plan of Care, and are required to have functional Individualized Back-Up Plans consistent with the participant's Plan of Care. When paid supports are scheduled to be provided by an enrolled provider of waiver services, that provider is responsible for providing all necessary staff to fulfill the health and safety needs of the participant.

• The identified enrolled provider of waiver services cannot use the participant's informal support system as a means of meeting the agency's individualized back-up plan, and/or emergency evacuation response plan requirements unless agreed to by the participant/family because the family prefers to make other arrangements.

• The identified enrolled provider of waiver services must have in place policies and procedures that outline the protocols the agency has established to assure that back-up direct support staff are readily available, lines of communication and chain-of-command have been established, and procedures are in place for dissemination of the back-up plan information to participants, their legal representatives, and support coordinators.

• It is the identified enrolled provider of waiver services' responsibility to develop the back-up plan and provide it to the Support Coordinator in a time frame that will allow it to be submitted for review/approval as a part of the Plan of Care.

• The Support Coordinator is responsible for working with the participant, his/her family, friends, and providers during initial and subsequent Plan of Care meetings to establish plans to address these situations.

• The Support Coordinator assists the participant and the support team members to identify individuals who are willing and able to provide a back-up system during times when paid supports are not scheduled on the participant's Plan of Care.

• All back-up plans must include detailed strategies and person-specific information that addresses the specialized care and supports needed by the participant as identified in the Plan of Care. Back-up plans must be updated no less than annually to assure information is kept current and applicable to the participant's needs at all times.

EMERGENCY EVACUATION PLANS

An Emergency Evacuation Response Plan must be developed in addition to the individual back-up plan, be included

in or attached to the participant's Plan of Care, and reviewed a minimum of once each Plan of Care year.

The Emergency Evacuation Response Plan provides detailed information for responding to potential emergency situations such as fires, hurricanes, hazardous materials release, tropical storms, flash flooding, ice storms, and terrorist acts.

The Emergency Evacuation Response Plan must include at a minimum the following components:
• Individualized risk assessment of potential health emergencies;

• Geographical and natural disaster emergencies, as well as potential for any other emergency conditions;

• A detailed plan to address participant's individualized evacuation needs

• Policies and procedures outlining the agency's protocols regarding implementation of Emergency Evacuation Response Plans and how these plans are coordinated with the local Office of Emergency Preparedness and Homeland Security;

• Establishment of effective lines of communication and chain-of-command, and procedures for dissemination of Emergency Response Plan to participants and Support Coordinators; and

• Protocols outlining how and when direct support staff and participants are to be trained in Emergency Evacuation Response Plan implementation and post-emergency protocols.

Training for direct support staff must occur prior to any worker being solely responsible for the support of the participant, and participants must be provided with regular, planned opportunities to practice the emergency evacuation response plan.

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f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

On acceptance of the waiver offer, the data management contractor offers Freedom of Choice of Support Coordination agencies.

The participant and his/her legal representatives are informed of the services available under the waiver during the initial contact that occurs no later than three (3) business days after the participant's linkage to the Support Coordination agency of his/her choice.

At initial contact and annually with the participant, the Support Coordinator discusses the Provider Freedom of Choice form and the availability of all services. The Support Coordinator is responsible for offering Freedom of Choice of providers.

Part of this contact involves a discussion of Freedom of Choice of enrolled waiver providers, the availability of all services, as well as what the participant and his/her legal representatives require from Support Coordination. The Freedom of Choice list includes all providers in the participant's region that are enrolled to provide specific waiver services. The Support Coordinator is responsible for maintaining a current listing of qualified providers.

The Support Coordinator is responsible for advising the participant that changes in providers can be requested at any time, but only by the participant or personal representative. The Support Coordinator will facilitate any request for a change of all providers.

The participant and his/her legal representative are encouraged by the Support Coordinator to interview or visit each provider agency they are interested in, in order to make informed choices.

The Support Coordinator can assist the participant/family members in setting up appointments to interview the different provider agencies, they can assist the participant/family members on what questions they should ask the

potential providers, and they can refer them to Families Helping Families or other advocacy groups. The Support Coordinator will assist with any other needs the participant/family members may have in selecting a qualified provider.

The Support Coordinator is not allowed to make recommendations and does not coerce the participant/family in making his/her decision.

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D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Service plans are subject to approval by the State Medicaid Agency (SMA). The SMA does not review and approve all service plans prior to implementation; however, all are subject to SMA's approval. The SMA completes reviews of participant records on a routine basis. Information reviewed includes, but is not limited to: development of an appropriate individualized person-centered service plan, completion of updates and revisions to the service plan, and coordination with other agencies as necessary to ensure that services are provided according to the service plan.

Medicaid Program Support and Waivers (MPSW) section staff has access to the Louisiana Support Coordination Application (LASCA) database which houses results of annual monitoring of Support Coordination Agency performance. These performance results include determinations of level of performance on service plan development, implementation, and service delivery. MPSW compares support coordination service plans and corresponding monthly Support Coordination Documentation (SCD) obtained from the support coordination agency with LASCA results to validate the support coordination monitoring process and to ensure participants' health and welfare. If discrepancies are identified, the Medicaid HCBS Oversight Committee addresses the discrepancies and determines actions necessary to resolve them on a systemic level, e.g. training or policy revision.

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

h. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☑ **Operating agency**
- ☑ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Support Coordinator is responsible for monitoring the implementation of the Plan of Care, the participant's health and welfare and the effectiveness of the Plan of Care in meeting the participant's needs and preferences.

The Support Coordinator contacts the participant and his/her legal representative within 10 working days after the initial Plan of Care is approved to assure the appropriateness and adequacy of services delivery.

Support Coordinators make monthly contacts with each participant and/or his/her legal representatives. One contact per quarter must be a face-to-face visit in the participant's place of residence.

During these contacts the Support Coordinator checks to make sure that:

- There is access to waiver and non-waiver services identified in the Plan of Care, including access to health services;
- The strategies to meet the participant's personal goals are being implemented and the effectiveness of the strategies;
- The services outlined in the Plan of Care are meeting the needs of the participant;
- The participant is satisfied with the service providers he/she has chosen;
- Services are being furnished in accordance with the Plan of Care;
- The participant's health and welfare needs are being met; and
- Back-up plans, if utilized, are effective and persons identified as responsible for back-up plans are still active in the participant's life.

Information from Support Coordinator's monitoring is maintained at the Support Coordination Agency's physical office. Support Coordinators must refer any findings during contacts or visits that appear to be out of compliance with federal or state regulations, and OCDD policies to the LGE for review and recommendations. If the finding cannot be resolved at the local level, LGE will refer it to the OCDD State Office to be resolved.

Revisions to the Plan of Care reflect the results of the monitoring. During the monitoring of the Plan of Care implementation, if changes are needed, a revision to the Plan of Care will be completed. All revisions must be reviewed and prior approved by the Support Coordination Supervisor or LGE as defined by OCDD policy . Emergency revisions to the Plan of Care must be submitted to the Support Coordination Supervisor/LGE as defined by OCDD policy within 24 hours or next business day. Routine revisions must be submitted to the Support Coordination Supervisor/LGE as defined by OCDD policy within at least seven (7) days prior to the change.

If a participant receives a denial, reduction or termination of services, appeal information is provided to them as outlined in Appendix F, section F-1.

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
D.a.i.a.1. Number and percentage of plans of care in which services and supports align with the participants' assessed needs. Percentage = Number of plans of care that meet the assessed needs of waiver participants / Total number of plans of care reviewed in the sample.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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 = 95% +/- 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.a.i.a.2. Number and percentage of plans of care in which services and supports align with the participant's assessed risk. Percentage = Number of plans of care that meet the assessed risks of waiver participants / Total number of plans of care reviewed in the sample..

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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 = 95% +/- 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

Performance Measure:
D.a.i.a.3. Number and percentage of plans of care that address participants' personal goals. Percentage = Number of plans of care that address participants' personal goals / Total number of plans of care reviewed in the sample.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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 = 95% +/- 5%
☐ Other Specify:	☑ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure 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:
D.a.i.c.1. Number and percentage of annual plans of care received prior to the expiration date of the approved plan of care. Percentage = Number of annual plans of care received by due date / Total number of plans of care due during reporting period.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
D.a.i.c.2 Number and percentage of participants whose plans of care were reviewed and revised to address changing needs. Numerator: Number of plans of care revised to address changing needs / Denominator: Total number of participants whose quarterly contact indicated a changing need.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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 = 95%+/-5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ Other Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure 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:
D.a.i.d.1 Number and percentage of participants who received all types of services specified in the plan of care. Numerator = Number of participants who received all types of services specified in the plan of care; Denominator = Total number of participants.

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

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☐ State Medicaid Agency	☐ Weekly	☑ 100% Review
☑ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☐ Representative Sample Confidence Interval =
☑ Other Specify: Medicaid Data Contractor	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.a.i.d.2 Number and percentage of participants who received services in the scope, amount, frequency and duration specified in their plan of care. Percentage

= Number of participants who received services in the scope, amount, frequency and duration specified in their plan of care / Total number of participants.

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
D.a.i.e.1. Number and percentage of waiver participants with a valid signature defined as the participant's/authorized representative's signature, on the plan of care which verifies that the freedom of choice was offered among waiver providers. Percentage = Number of waiver participants with a valid signature on the plan of care / Total number of participants reviewed in the sample.

Data Source (Select one):
Record reviews, on-site
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 = 95% +/- 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.a.i.e.2. Number and percentage of waiver participants with a valid signature, defined as the participant's/authorized representative's signature, on the plan of care which verifies that available services were discussed with the waiver participants. Percentage = Number of participants with a valid signature on the plan of care / Number of participants reviewed in the sample.

Data Source (Select one):
Record reviews, on-site
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 = 95% +/- 5%

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

Data Aggregation and Analysis:

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

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.
For all performance measures except D.a.i.c.1(Updated prior to plan expire), D.a.i.d.1, and D.a.i.d.2, OCDD LGE staff perform monitoring of support coordination agencies at least annually utilizing the OCDD Support Coordination Monitoring Tools: Participant Interview, Participant Record Review, Support Coordinator Interview, and Agency Review. The sample size will be large enough for a confidence level of 95% + or – 5%. The number of participants from the statewide sample to be included in each support coordination agency (SCA) sample will be proportional to the percentage of participants linked to each agency on the date the sample is generated. An SCA's sample size will be determined separately for each region in which the SCA operates.

For all performance measures except D.a.i.c.1, D.a.i.d.1 and D.a.i.d.2., the specific criteria for these measures are found in the OCDD Interpretive Guidelines for the OCDD Participant Record Review with a parallel set of guidelines entitled "Guidelines for Support Planning" for support coordinators.

D.a.i.c.1 measures the first part of sub-assurance c., whether the service plan was updated at least annually. The Medicaid Data contractor is responsible for prior authorization of services and authorizes services based up receipt of an approved service plan. Data is then entered into the contractor data system which provides 100% representativeness for this measure.

D.a.i.c.2 measures the second part of sub-assurance c., whether service plans are updated when warranted by changes in the waiver participant's needs. The data source is the OCDD Participant Record Review and the responsible party for data collection/generation is the LGE.

D.a.i.d.1, and D.a.i.d.2: the Medicaid data contractor prior authorizes services according the approved service plan and enters post authorization of service once a provider has verified service delivery. This data is utilized to determine whether the participant received the type, scope, amount, duration, and frequency specified in the service plan. The method for validating this information is collected by the Support Coordination Agency during the quarterly reviews in the home and entered into the Case Management Information System (CMIS) which is accessed by the Medicaid Data Contractor to validate if the services have been delivered in the type, amount, frequency, duration, of services identified in the plan of care. The Support Coordination Agency and the LGE review the data quarterly for these measures.

Regarding D.a.i.e.1 and D.a.i.e.2, a valid signature on the service plan is either the signature of a participant with the capacity to approve the plan or a person who has been designated on the OCDD Authorized Representative Form as such.

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.
D.a.i.c.1: The LGE receives quarterly reports from the Medicaid Data Contractor for review. If the participant's annual Plan of Care (POC) was not submitted within the required timeline, the LGE will contact the support coordination agency. The support coordination agency will have 10 days to respond identifying why the plans of care were not timely submitted. Depending upon the scope and persistence of such problems, OCDD may pursue sanctions as outlined in the Support Coordination Performance Agreement including withholding payment.

D.a.i.d.1: The LGE receives quarterly reports from the Medicaid Data Contractor in order to review trends and patterns of under-utilization of services. If this appears to be an isolated event, the LGE will follow up with the support coordination agency to determine the reason and the support coordinator shall revise the POC as necessary. If the POC revision is not submitted within the timeframe, OCDD shall pursue sanctions as outlined in the Support Coordination Performance Agreement. If this appears to be widespread, the LGE will consult with OCDD State Office who will then bring the issue to the Performance Review Committee and the OCDD Executive Management team for review and resolution.

D.a.i.d.2: The LGE receives quarterly reports from the Medicaid Data Contractor in order to review trends and patterns of under-utilization of services. If the LGE discovers under-utilization due to a particular agency, among certain services, lack of availability of services, etc., the LGE will consult with OCDD State Office who will then bring the issue to the Performance Review Committee and the OCDD Executive Management Team for review and resolution.

The State's method for addressing individual problems identified through the remaining performance measures is as follows: 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:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one)*:

- ( ) **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Self-Direction is a service delivery option which allows participants (or their authorized representative) to exercise Employer Authority in the delivery of their authorized self-directed services(Community Living Supports).

Participants are informed of all available services and service delivery options, including Self-Direction, at the time of the initial assessment, annually, or as requested by participants or their authorized representative. Participants, who are interested in Self-Direction, need only notify their Support Coordinator who will facilitate the enrollment process.

A contracted fiscal/employer agent is responsible for processing the participant's employer-related payroll, withholding and depositing the required employment-related taxes, and sending payroll reports to the participant or his/her authorized representative.

Support Coordinators assist participants by providing the following activities:

- The development of the participant's Plan of Care;
- Organizing the unique resources the participant needs;
- Training participants on their employer responsibilities;
- Completing required forms for participation in Self-Direction;
- Back-up service planning;
- Budget planning;
- Verifying that potential employees meet program qualifications; and
- Ensuring participants' needs are being met through services.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- (●) **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ( ) **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ( ) **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- [x] **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- [ ] **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- [ ] **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one)*:

- ( ) **Waiver is designed to support only individuals who want to direct their services.**
- ( ) **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- (●) **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

To be eligible, the participant must:

• Be able to participate in the Self-Direction option without a lapse in or decline in quality of care or an increased risk to health and welfare. Health and welfare safeguards are articulated in Appendix G of this document and include the application of a comprehensive monitoring strategy and risk assessment and management system.

• Complete the training programs (e.g. initial enrollment training) designated by OCDD.

• Understand the rights, risks, and responsibilities of managing his/her own care, effectively managing his/her Plan of Care; or if unable to make decisions independently have a willing decision maker (authorized representative as listed on the participant's Plan of Care) who understands the rights, risks, and responsibilities of managing the care and supports of the participant within their Plan of Care.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Participants are informed of the Self-Direction option at the time of the initial assessment, annually, or as requested by participants or their authorized representative. If the participant is interested, the Support Coordinator will provide more information on the principles of self-determination, the services that can be self-directed, the roles and responsibilities of each service option, and the benefits and risks of each service option, and the process for enrolling in Self-Direction.

Prior to enrolling in Self-Direction, the participant or his/her authorized representative is trained by the support coordinator on the material contained in the Self-Direction Employer Handbook. This includes training the participant (or his/her authorized representative) on the process for completing the following duties:

- Best practices in recruiting, hiring, training, and supervising staff;
- Determining and verifying staff qualifications;
- The process for obtaining criminal background checks on staff;
- Determining the duties of staff based on the service specifications;
- Determining the wages for staff within the limits set by the state;
- Scheduling staff and determining the number of staff needed.
- Orienting and instructing staff in duties;
- Best practices for evaluating staff performance;
- Verifying time worked by staff and approving timesheets;
- Terminating staff, as necessary;
- Emergency Preparedness planning; and
- Back-up planning.

This training also includes a discussion on the differences between Self-Direction and other service delivery options (which includes the benefits, risks, and responsibilities associated with each service option) and the roles and responsibilities of the employer, support coordinator, and fiscal/employer agent.

Participants who choose Self-Direction are provided with a copy of the Self-Direction Employer Handbook by the Support Coordinator or OCDD. Participants verify that they have received the required training from their support coordinator and a copy of the Self-Direction Employer Handbook by signing the "Service Agreement" form.

The Self-Direction Employer Handbook was developed through contribution and feedback from participants and families to ensure that the information is easy-to-understand and addresses participants' perspective.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

○ **The State does not provide for the direction of waiver services by a representative.**

◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☑ **Waiver services may be directed by a legal representative of the participant.**

☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Participants have the right to have a non-legal authorized representative perform the employer or managing employer responsibilities. The support coordinator is responsible to ensure that the selected authorized representative agrees to fulfill the responsibilities of the employer or managing employer by ensuring the completion of the standard agreement form. If an authorized representative is desired by the participant, they must:

• Effectuate the decision the participant would make for himself/herself;
• Accommodate the participant, to the extent necessary that they can participate as fully as possible in all decisions that affect them;
• Give due consideration to all information including the recommendations of other interested and involved parties; and
• Embody the guiding principles of self-determination. A participant may designate any person 21 years of age or older as an authorized representative
unless a legal representative has been designated by a court or is otherwise limited by existing or pending legal action prohibiting someone from
serving as an authorized representative.
An authorized representative may not receive payment for functioning as an authorized representative, nor may they receive payment for any waiver service provided to support the participant.

The support coordinator must recognize the participant's authorized representative as a decision-maker, and provide the authorized representative with all of the information, training, and support the support coordinator would typically provide to a participant who is self-directing.

The support coordinator must fully inform the authorized representative of the rights and responsibilities of an authorized representative in accordance with established procedures.

The support coordinator must have the authorized representative review and sign a standard agreement form, which must be given to the authorized representative and maintained by the support coordinator. The agreement lists the roles and responsibilities of the authorized representative; asserts that the authorized representative accepts the roles and responsibilities of this function; and asserts that the authorized representative will abide by Medicaid Waiver policies and procedures.

Service plan monitoring takes place with each participant. Several questions on the standard service plan monitoring tool can prompt the identification of any issues with the authorized representative not acting in the best interest of the participant. Issues noted on the monitoring tool are addressed by Supports Coordinators, the LGE and OCDD. The support coordinator is required to address and report any issues identified with the authorized representative's performance including but not limited to compliance to Medicaid Waiver policies on incident reporting and report any incident of suspected fraud or abuse.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. **Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Community Living Supports	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Fiscal management services are provided by a contracted fiscal/employer agency, procured through the Department's Request for Proposal (RFP) process.

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

The charges for fiscal management services will be paid through a monthly fee per participant by the Bureau of Health Services Financing (BHSF).

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☑ **Assist participant in verifying support worker citizenship status**
☑ **Collect and process timesheets of support workers**
☑ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

☐ **Maintain a separate account for each participant's participant-directed budget**
☐ **Track and report participant funds, disbursements and the balance of participant funds**

- ☐ **Process and pay invoices for goods and services approved in the service plan**
- ☐ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

Specify:

Additional functions/activities:

- ☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☑ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☐ **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

Specify:

iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The Bureau of Health Services Financing (BHSF) is responsible for the monitoring of the performance and financial integrity of FMS and the terms of the contract. BHSF performs monitoring of the fiscal/employer agent's claims payment activities, billing history, and adherence to the terms of the contract on an on-going basis. OCDD provides BHSF with any data or other relevant information regarding the fiscal/employer agent's performance. If any problems are identified (regardless of the origination of issue), BHSF will require a corrective action plan from the fiscal/employer agent and will monitor its implementation.

Semi-monthly statements of participants' employer related payroll activities are sent to the participant, BHSF, and OCDD for review to monitor the utilization of Plan of Care units and payments.

In addition, BHSF requires that the fiscal/employer agent submit an annual independent audit by a Certified Public Accountant (CPA) to verify that expenditures are accounted for and disbursed according to generally accepted accounting principles.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

- ☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

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

Support Coordinators will inform participants of the Self-Direction option at the time of initial assessment, annually, and as requested by participants or their authorized representative. If participants or their authorized representative are interested, the Support Coordinator shall provide detailed information regarding the differences between service delivery options, roles and responsibilities in Self-Direction, and benefits and risks associated with Self-Direction. The Support Coordinator is responsible for providing the participant or their authorized representative with the Self-Direction Employer Handbook.

If the participant decides that he/she would like to participate in this option, the support coordinator shall notify the OCDD LGE and the Self-Direction Program Manager. Once notified by OCDD that the participant is eligible to participate in Self-Direction, the Support Coordinator facilitates the scheduling of the initial Self-Direction planning meeting.

The Support Coordinator will assist participants and their authorized representative with determining the number of direct care workers needed, preparing and completing of required forms as needed, determining what resources the participant will need to participate in Self-Direction, and arranging for other needed supports and services. The Support Coordinator will be responsible for training the participant (or his/her authorized representative) on the material contained in the Self-Direction Employer Handbook, which includes information on recruiting, hiring, and managing staff, with the participant.

The Support Coordinator will then facilitate planning and preparation of the Plan of Care/revision, which will be submitted to the OCDD LGE for approval. Support Coordinator is responsible for monitoring service delivery and implementation dates, and updating the participant's Plan of Care annually or as changes in service needs occur. The OCDD LGE will approve changes as needed.

Support Coordinators also act as a resource and advocate for the participant in identifying and obtaining formal and informal supports, assist the participant in working with the fiscal/employer agent, and provide employment support to participants inclusive of the duties specified in Appendix E-2-a-ii.

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Nursing	☐
Respite Services - Out of Home	☐
Professional Services	☐
Personal Emergency Response System	☐
Transportation - Community Access	☐
Housing Stabilization Service	☐
Day Habilitation	☐
Dental	☐
Community Living Supports	☐
One-Time Transitional Services	☐
Host Home	☐
Supported Employment	☐
Companion Care	☐
Shared Living Services	☐
Environmental Accessibility Adaptations	☐
Support Coordination	☑
Housing Stabilization Transition Service	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Adult Day Health Care	☐
Assistive Technology/Specialized Medical Equipment and Supplies	☐
Prevocational Services	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

All waiver participants have access to independent advocacy through the Advocacy Center in Louisiana.

The Advocacy Center has a multi-disciplinary staff of lawyers, paralegals, client advocates and support staff who provide the following services: Legal Representation, Advocacy Assistance, Information and Referral, Systems Advocacy, Education and Training, Self-Advocacy, Publications, and Outreach.

The Advocacy Center is Louisiana's protection and advocacy system. Federal law requires that a protection and advocacy system operate in every state to protect the rights of persons with mental or physical disabilities. The Advocacy Center is also funded by the state to provide legal assistance to people residing in nursing homes in Louisiana and to advocate for the rights of group home and nursing home residents. Among the diverse services offered are legal representation, information and referral, outreach and training. The Advocacy Center also provides limited legal services as well as outreach and education to senior citizens of Orleans, Plaquemines and St. Tammany under contract with the Councils on Aging in those parishes.

The Advocacy Center helps to give clients the skills and knowledge to act on their own behalf. The Advocacy Center provides a variety of booklets, reports, flyers, and other resources pertaining to persons 60 years or older and persons with disabilities. The Advocacy Center does not provide other direct services or perform waiver functions that have a direct impact on a participant.

Support Coordinators are responsible for informing participants of the availability of independent advocacy.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method,

including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Selection of the Self-Direction option is strictly voluntary and the participant may choose at any time to withdraw and return to traditional payment option. Withdrawal requires a revision of the Plan of Care, eliminating the FMS and indicating the Medicaid-enrolled waiver service provider of choice. Procedures must follow those outlined in the Support Coordination Manual. Proper arrangements will be made by the support coordinator to ensure that there is no lapse in services.

Should the request for voluntary withdrawal occur, the participant will receive counseling and assistance from his/her Support Coordinator immediately upon identification of issues or concerns in any of the above situations

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Involuntary termination requires a revision of the Plan of Care, eliminating the fiscal/employer agency and indicating the Medicaid-enrolled waiver service provider of choice. Procedures must follow those outlined in the Support Coordination Manual.

Involuntary termination may occur for the following reasons:

• • If the participant does not receive self-directed services for ninety days or more.

• • If at any time OCDD determines that the health, safety, and welfare of the participant is compromised by continued participation in the Self-Direction option, the participant will be required to return to the traditional payment option.

• • If there is evidence that the participant is no longer able to direct his/her own care and there is no responsible representative to direct the care and the Support Coordinator agrees, then the participant will be required to return to the traditional payment option.

• • If the participant or the authorized representative/co-signer consistently:

o Permits employees to work over the hours approved in the participant's Plan of Care or allowed by the participant's program

o Places barriers to the payment of the salaries and related state and federal payroll taxes of direct support staff, as documented by the fiscal/employer agent.

o Fails to provide required documentation of expenditures and related items, or fails to cooperate with the fiscal/employer agent or support coordinator in preparing any additional documentation of expenditures, as documented by the fiscal/employer agent and/or the Support Coordinator.

o Violates Medicaid program rules or guidelines of the of the Self-Direction option.

• •If the participant becomes ineligible for Medicaid and/or home and community-based waiver services, the applicable rule for case closure/discharge will be applied.

• • If there is proof of misuse of public funds.

When action is taken to terminate a participant from Self-Direction involuntarily, the Support Coordinator immediately assists the participant in accessing needed and appropriate services through the ROW and other available programs, ensuring that no lapse in necessary services occurs for which the participant is eligible. There is

no denial of services, only the transition to a different payment option. The participant and Support Coordinator are provided with a written notice explaining the reason for the action and citing the policy reference.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

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

Appendix E: Participant Direction of Services

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

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

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

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

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

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

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

☑ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☑ **Hire staff common law employer**

- [x] **Verify staff qualifications**
- [x] **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

It is included in the FMS contract.

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

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

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

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

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

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

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

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

1) A finding by the office that the person does not qualify for system entry;
2) Involuntary reduction or termination of a support or service;
4) Discharge from the system; and/or
5) Other cases as stated in office policy or as promulgated in regulation.

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

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

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

In accordance with 42CFR 431.206, 210 and 211, participants receiving waiver services, and their legal representatives are sent a certified letter with return receipt to ensure the participant receives it by the appropriate OCDD LGE providing 10 days advance and adequate notification of any proposed denial, reduction, or termination of waiver services. Included in the letter are instructions for requesting a fair hearing, and notification that an oral or written request must be made within ten

days of receipt of a proposed adverse action by the OCDD LGE in order for current waiver services remain in place during the appeal process. If the appeal request is not made within ten days, but is made within thirty days, all Medicaid waiver services are discontinued on the eleventh day; services that are continued until the final decision is rendered are not billable under the Medicaid waiver. If the final decision of the Administrative Law Judge is favorable to the appellant, services are re-implemented from the date of the final decision. An appeal hearing is not granted if the appeal request is made later than thirty days following receipt of a proposed adverse action sent by the OCDD Local Governing Entity (LGE). Once a request for an appeal is received, the OCDD LGE must submit the request to the Division of Administrative Law - A: Louisiana Department of Health no later than seven calendar days after receipt. A copy of the letter and the response/request is kept in the participant's record at the appropriate OCDD LGE.

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

Anyone requesting an appeal has the right to withdraw the appeal request at any time prior to the hearing. The appellant may contact the Division of Administrative Law (DAL) directly, or may request withdrawal through the OCDD Local Governing Entity (LGE). Requests for withdrawal are kept in the participant's record at the appropriate OCDD LGE.

Louisiana Administrative Code Title 48, Part I, Subpart 3, Chapter Home and Community Based Service Provider Licensing Standards, Subchapter C, Admission, Transfer and Discharge Criteria, require that enrolled providers of waiver services provide participants and their legal representatives notice in writing at least thirty days prior to the transfer or discharge from the provider agency with the proposed date of the transfer/discharge, the reason for the action, and the names of personnel available to assist the participant throughout the process. The enrolled provider of waiver services must also provide the participant and his/her legal representatives with information on how to request an appeal of a decision for involuntary discharge. A copy of the notice of intent to transfer/discharge, and information that was provided on how to access the appeal process is kept in the participant's record at the enrolled provider of waiver services' physical location of business.

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

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

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

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

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

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

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

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

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

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

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

• HSS and OCDD LGE, as well as support agencies such as Families Helping Families distribute the HSS complaint line information when assisting participants and their legal representative(s). Direct service providers are also required to give the complaint line number to all participants.

• Support Coordinators are responsible for informing participants and their legal representative(s) initially, annually or whenever information about the system is requested that filing a grievance or complaint is not a pre-requisite or substitute for a Fair Hearing.

The OCDD LGE staff checks to make sure that this information has been relayed to participants during the pre-certification visit.

• If the OCDD 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 OCDD LGE staff will refer the complaint by fax to the HSS complaint line within 24 hours for tracking and distribution.

• HSS triages all complaints in the following manner:

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

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

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

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Critical events or incidents that are required to be reported 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 LDH 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
- •Medication Errors

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.
The provider must submit a written critical incident report via the LDH incident reporting system by the next business day after 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.

• The state provides information to the participant, his/her family, legal representative or authorized representative during initial waiver planning/certification and annually thereafter.

Abuse, neglect and exploitation is discussed with the participant and/or families or legal representative initially by the support coordination agency, the local governing entity, and the provider agency. During the initial planning process, participants receive information regarding their right to be free from abuse, neglect and exploitation and how to report. Each participant receives a copy of the OCDD Participant Rights and Responsibility form which contains the phone number to the Health Standards Complaint line as well as the phone number to the different protective services agencies. (Elderly Protective Services (EPS), Adult Protective Services (APS) or Child Protected Services. CPS).

During the annual plan of care meeting process, the OCDD Rights and Responsibilities form is reviewed and discussed, which includes a conversation regarding abuse, neglect, and exploitation. A copy of the OCDD Rights and Responsibilities form is given to the participant/family and is retained in the home. The form contains the phone number to the Health Standards Complaint line as well as the phone number to the different protective services agencies. (Elderly Protective Services (EPS), Adult Protective Services (APS) or Child Protected Services. CPS).

Additionally, on a quarterly basis, the Support Coordinator is required to conduct a face to face visit with the participant (and/or families or legal representatives as appropriate). As part of the visit, the Support Coordinator ensures that the Health Standards Complaint line number as well as the other protective services agencies are available to the participant. Any complaint called into the Health Standards complaint line that constitutes abuse, neglect, or exploitation results in a complaint being generated by Health Standards and routed to the appropriate agency (Elderly Protective Services (EPS), Adult Protective Services (APS) or Child Protected Services. CPS).

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.

Reports/Evaluation of Reports/Investigations/Timeframes:

• Direct Support Provider:
o Once notification of a Critical Incident is received by the provider agency, within two (2) hours of discovery, they must inform the support coordinator of the incident. The provider must assure that the participant is protected from further harm and respond to any emergency needs of the participant.
o If abuse/neglect/exploitation/extortion is suspected, provider must immediately contact the appropriate protective service agency (CPS, APS/EPS). The provider must cooperate with the appropriate protective service agency once the agency has been notified and an investigation commences. The provider is required to provide relevant information, records, and access to members of the agency conducting the investigation.
o The provider participates in planning meetings to resolve the Critical Incident or to develop strategies to prevent or mitigate the likelihood of similar incidents in the future.
o The provider tracks Critical Incidents in order to identify remediation needs and quality improvement goals and to determine the effectiveness of strategies employed for incident resolution.

• Support Coordinator:
o Receives Critical Incident Report from provider within 24 hours of the incident. Enter the critical incident information into the web-based Online Tracking System (OTIS) by close of the next business day. Enter follow-up case notes within 6 business days after the initial critical incident is received from the direct service provider or discovery by the support coordinator. The support coordinator must collaborate with the provider to assure that the participant is protected from further harm and respond to any emergency needs of the participant.
o If abuse/neglect/exploitation/extortion is suspected, support coordinator must immediately contact the appropriate protective service agency (CPS, APS/EPS).
o Convene planning meetings that may be required to resolve the critical incident or to develop strategies to prevent or mitigate the likelihood of similar critical incidents from occurring in the future.
o Obtain the participant summary from the web-based Online Tracking System (OTIS) after closure by the OCDD Regional Office or Human Service Authority/District and forward to the provider and participant within 15

days.

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

- OCDD LGE CSRA, or designee:

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

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

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

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

- OCDD LGE Staff:

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

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

o Make timely referrals to other agencies as necessary.

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

- CPS (ages 0 to 17):

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

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

- APS/EPS(ages 18 and above):

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

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

- Health Standards Section:

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

- Law Enforcement:

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

- OCDD State Office (Quality Section):

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

o Provides technical assistance to the OCDD Local Governing Entity (LGE)as needed. OCDD State Office (Quality Section) identifies necessary remediation to be taken by the direct service provider, support coordinator/agency, and OCDD LGE staff.

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

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

investigation results:

• The OCDD LGE staff completes the participant summary for all Critical Incidents within 30 days of the Critical Incident.

• The support coordinator obtains the participant summary and forwards a copy to the participant and direct service provider within 15 days of closure by the OCDD LGE.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

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

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

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

• OCDD provides the State Medicaid Agency quarterly reports which include all Critical Incidents.
Methods for overseeing the operation of the incident management system, including how data are collected, compiled, and used to prevent re-occurrence:

• Periodically, the OCDD LGE shall select a sample of critical incidents to review for adherence to policy including a review to determine if all necessary actions were taken to address and resolve critical incidents.

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

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

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

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

• OCDD utilizes the information and data collected on critical incidents for quality management purposes, including but not limited to the following:
o Development and review of reports to assure that follow-up and case closure of critical incidents occur according to this policy on an on-going basis for individual cases and quality review of aggregate data
o Quarterly analysis of data to identify trends and patterns for effective program management that ensures the safety and well-being of people receiving OCDD supports and services and ensures that people receive quality supports and services from OCDD
o Annual analysis of data to determine the effectiveness of quality enhancement goals and activities; and
o Identification of participants who experience frequent critical incidents and will need strategies to mitigate risk included in their Plan of Care on an on-going basis by support coordination agencies as they perform their quarterly Plan of Care reviews.

Frequency of oversight activities:
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 if there are any trends and patterns that indicate further action is needed. MPSW also monitors the data reports to see if remediation activities implemented in the previous quarter were effective in improving data results for the current period. If remediation activities were not effective, the SMA will meet with the operating agency to address any changes needed to remediation strategies in order to improve results. The SMA will continue to follow up with the operating agency to evaluate remediation for effectiveness.

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

Appendix G: Participant Safeguards

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

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

○ **The State does not permit or prohibits the use of restraints**

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

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

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

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

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

•Medical: 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 operating agency provides Bureau of Health Services Financing (Medicaid agency) with aggregate data and reports which are inclusive of any reported restraint use.

Seclusion is not permitted.

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

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

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

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

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

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

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

•Enrolled providers of waiver services are required by licensing regulations to ensure that non-

intrusive, positive approaches to address the meaning/origin of behaviors that could potentially cause harm to self or others.

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

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

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

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

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

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

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

Preventive strategy examples:

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

Teaching examples:

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

Intervention examples:

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

Again, it should be noted that these are only examples in each category of possible strategies. There are many other alternatives that may be used. Each plan is tailored to meet the participant's needs and is developed by different professionals.

The use of restraints requires prior permission. Informed consent is obtained from the participant or his/her legal guardian relevant to the participant's consent for implementation of the plan. At a minimum, informed consent includes the essential components necessary for understanding the potential risks and benefits of the plan. Also, the participant or legal guardian shall be informed of the right to withhold or withdraw consent at any time. If a restraint is unplanned, as in emergency situations, prior permission is not obtained. However, unplanned restraints are based on the fact that the restraint is a

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

When restraint is used for behavior support procedures, a licensed psychologist authorizes the use. When restraints are used for medical protective supports and procedures (as those applied as a health-related protection) a licensed physician, licensed dentist, or licensed podiatrist, authorizes the use. The following practices are employed to ensure the health and safety of individuals when restraints are used:

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

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

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

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

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

• The OCDD LGE staff may refer reports of use of restraint to the State Office Review Committee for guidance and recommendations.

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

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

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

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

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

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. See G-2 d. Critical incidents – Responsibility for Review of and Response to Critical Events or Incidents

○ **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.See G-2 d. Critical incidents – Responsibility for Review of and Response to Critical Events or Incidents

○ **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.

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

If the participant 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 attends to participants that 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 LDH-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 LDH-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 in addition to 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.

Medication errors are a reportable incident category in the OCDD critical incident reporting system. Direct service providers and support coordinators are responsible for reporting medication errors that result in the need for medical intervention for the participant, within timelines specified in OCDD operational instruction F-5. Resolution of the incident requires documentation of immediate actions taken by the direct service provider to assure health & safety of the participant as well as preventative actions that improve systemic

performance within the direct service provider agency. Aggregate totals of medication errors are reviewed by the LGEs and OCDD Quality Enhancement Section on a quarterly basis to identify patterns. The OCDD Mortality Review Committee reviews all waiver deaths monthly and identifies any concerns regarding medication administration; unexplained errors on the part of direct service provider staff are referred to the HSS for investigation.

OCDD will disseminate reports to LGE waiver section management and the OCDD Performance Review Committee. 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) quarterly.

OCDD's discovery of medication errors and related concerns may surface at any time and result from the support coordinator's and LGE's ongoing, real-time reviews of critical incident reports (which include medication errors), from LGE on-site visits or support coordinators quarterly on-site reviews and monthly contacts with participants, and from direct complaints lodged by participants, families or other stakeholders which may be phoned into OCDD State Office or 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 LDH Bureau, Section or Program Office with legal authority to investigate, sanction, recoup or take other actions to protect waiver participants (i.e., Protective Services offices; Health Standards Section; BHSF/Program Integrity Section).

MPSW reviews aggregated 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**

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:

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:

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
☐ 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 & percent of reported use of restrictive interventions/seclusion where a prevention plan has been developed as a result of an incident. Numerator= Number of restrictive interventions/seclusion where a prevention plan has been developed as a result of an incident. Denominator= total # of incidents reporting use of restrictive interventions or seclusion

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

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**
	☐ **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 ROW 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.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:

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 Residential Options Waiver (ROW) 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 Residential Options Waiver (ROW), 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 or annual 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):*

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).

All Medicaid providers will be required to fulfill the requirements under the provision of the Single Audit Act to maintain Medicaid enrollment. The Louisiana Legislative Auditor (LLA) is the entity that is responsible for conducting the periodic independent audit of the waiver program under the provisions of the Single Audit Act. Medicaid staff will ensure that any provider receiving the amount of funds specified in the Single Audit Act will be required to provide a copy of the independent audit for continued Medicaid enrollment on an annual basis. Disenrollment will occur as a result of non-compliance. Program Integrity's Surveillance and Utilization Review (SUR) Unit is responsible for conducting post-payment reviews of all fee-for-service Medicaid providers. The post-payment review process used by the Program Integrity Section within the Louisiana Department of Health (LDH) is described in the Louisiana Surveillance and Utilization Review Subsystem (SURS) Rule and the Medical Assistance Program Integrity Law (MAPIL). The SURS Rule is available online through the Louisiana Register at the following website address: http://www.doa.la.gov/osr/reg/1211/1211.pdf (Pages 97-111 of the pdf or 2774-2788 of the hardcopy). Specifically the rule may be found through the following citation: Louisiana Administrative Code 50:I.Chapter 41.

Waiver providers are selected and profiled. The providers that meet the exception criteria in the Surge run are screened/reviewed. Cases on Waiver providers are derived from multiple sources such as ad hoc data mining, the Surge by Region run, the HCPCs Outlier run, projects (such as services billed while the recipient is in the hospital) and complaints. Complaints are received via mail, fax, website and hotline. Sources for cases come from complaints, referrals (internal and external) and data mining (regularly scheduled data runs and ad hoc data runs). A team made up senior analysts and a supervisor triages all complaints. Onsite visits are determined on a case by case basis and depends on the severity of the complaint. The primary means of receiving documentation needed for the review is via mail, fax or electronic. Reasons for on-site vary. If a provider does not make available documentation requested for a review, the SURS analyst may be instructed to perform an on-site. If multiple complaints are received on the same provider, an on-site may be the method of retrieving documentation. A random sample of recipients is selected or a specific recipient may be addressed depending on the details of the complaint or reason(s) for the case opening. Sample selection uses a univariant sampling technique which allows all recipients equal chance of being selected. There is no weighting of recipients due to number of claims, amount paid, or any other factor. Generally, a scientific sample of 20 recipients is used. The basic logic for the scientific sampling process is:
1) A universe of claims/encounters is defined and the claims/encounters meeting the selection criteria are extracted.
a. Some criteria can be Provider ID, Procedure Codes, Medicare coverage, or other identifying claim/encounter characteristic.
2) The universe is read and each of the unique recipient ids are extracted.
3) Each unique recipient id is assigned a "uniform" random number using the SAS built-in UNIFORM () function. This is to ensure that each recipient will have an equal chance of being selected.
4) The recipients are sorted using the random number, as to create a random listing of the recipient ids.
5) The recipients with the lowest random numbers assigned to them are selected until the requested sample size is reached.
6) The claim/encounter records associated with the selected recipient ids are extracted for reporting and analysis.

All documentation to support the services billed are requested: timesheets, daily logs, etc. Additional information is also requested for the direct service worker which includes employee records and any other associated documentation from the provider agency. Complete copies of the personnel files of all employees employed during the time period reviewed who provided care for the recipients on the attached page. List names, title, education levels, and job descriptions. Include copies of applications, driver's licenses, current addresses, results of criminal background checks, and all certifications and/or trainings.

The SURS data mining team produces computer runs that generate open cases. Providers whose income spikes from one period to another are identified through exception processing and will generate case openings.

Post-payment reviews are triggered when potential fraud, waste and abuse is identified either through a complaint, referral or data mining. SURS opens complaint cases throughout the year after the triage process. Some data mining runs (such as SURGE or Spike runs, date of death runs, outlier runs, etc.) are done on a fixed schedule. Other data mining runs are done on an ad hoc basis where project cases are opened and are usually policy-focused. For example, providers billing for in-home services while the recipients are hospitalized.

SURGE Run is a computer run that is produced on a regular basis that identifies providers that meet a set of criteria and/or conditions. The run looks for providers with incomes that surge.
Enrolled providers are divided by regions established by the Louisiana Department of Health (LDH). The computer runs are done by region. There are a total of 10 computer runs. There are 9 in-state runs and 1 out-of-state run. Runs are done on a monthly basis with the exception of the month of June and December. Providers are selected based on 3 criteria: location, amount paid and percent change in amount paid.
•First, a provider must be located in the region that is being reviewed.
•Secondly, a provider must have generated a minimum dollar amount paid in a 12 month period to be included for processing.
•And finally, a provider must have had a "surge" in income from a six month period in one year to a six month period in another year.

SURGE by Region (SBR) Run is a production run that is used to monitor the activity of providers enrolled in the Louisiana Medicaid Program. The run identifies providers with a significant increase or "spike" in the billing. The basic concept of the SBR run is to compare a provider's income for six months in one year to his or her income for six months in the following year. This run is a valuable tool because any significant increase in a provider's income is detected and a review of the provider's billing pattern is done to determine the reasons for the change. Enrolled providers are divided by regions established by the Louisiana Department of Health (LDH). The computer runs are done by region. There are a total of 10 computer runs. There are 9 in-state runs and 1 out-of-state run. Runs are done on a monthly basis with the exception of the month of June and December. Providers are selected based on 3 criteria: location, amount paid and percent change in amount paid. First, a provider must be located in the region that is being reviewed. Secondly, a provider must have generated a minimum dollar amount paid in a 12 month period to be included for processing. And finally, a provider must have had a "surge" in income from a six month period in one year to a six month period in another year. The provider types are divided into 3 groups based on an income threshold: Group A = $75,000, Group B = $150,000 and Group C = $300,000. Providers in each group have to meet or exceed the minimum income threshold. Cases are opened using the following process. A SBR run is submitted in J-SURS according to the run schedule. The run generates a list of providers who meet the criteria or who except. A basic screening is performed on each of the providers on the exception list to determine if a case will be opened. Cases that pass the screening are opened and tracked as a "SURGE" case type in the SURS database. When a SURGE case is opened, two reports are available to assist with the case analysis: an individualized exception profile on the provider and a report with peer group data. An exception profile on the provider gives information specific to the individual servicing provider such as dollar and claim averages per recipients, recipients by age and gender, reimbursements by dollar categories, percent changes, etc. for six months in one year as well as metrics for six months in the following year. Top procedure codes paid and top diagnoses billed for the individual servicing provider are displayed for each six month period. A peer group comparison run is done on the provider type and specialty that includes a provider ranking by amount paid, top procedure codes paid, and top diagnoses billed. The reports deliver a comparison of the provider from one period to another period as well as a comparison of the provider to his or her peer group.

Ad hoc data runs are designed to look at more specific issues like waiver services billed while the recipient is in the hospital or dates of service after a recipient's date of death or direct service workers employed who are excluded from participating in the Medicaid program.

A variety of professional staff are used to perform fraud, waste and abuse reviews. Analysts conducting the reviews are primarily Registered Nurses; however, there are dental hygienists and social workers on staff. In addition to the analysts, professional consultants are utilized such as physicians with different specialties, dentists, etc. Complaints are sent to the triage team, which is made up of professional staff that screen complaints for fraud, waste and abuse. If fraud, waste and abuse is involved, further research is done to determine if a comprehensive or focused review is done. Referrals are also made to professional licensing boards, local law enforcement, the Medicaid Fraud Control Unit (MFCU), child/adult protection, DHH program managers, etc. All SURS cases are worked by a professional staff analyst.

Once the review is completed by the analyst, the Quality Assurance (QA) team reviews the findings closely. Also, during the review process, medical consultants may give input as well as the Program Integrity Director and LDH

program managers. After the case has completed the QA process, the findings of the review are also reviewed by the RN Supervisors. From there, the correspondence to provider detailing the results of the audit is presented by the RN Supervisors to the Program Integrity Director and manager. After the findings letter is sent, the provider is entitled to an informal hearing as well as an appeal hearing and judicial review. Once the review findings have been confirmed and finalized, any overpayments due are collected. The provider receives a recoupment letter with the specific areas of review. The provider has an opportunity to submit additional information, request an informal hearing with LDH or request an appeal. The provider can pay the overpayment amount in full or request a payment plan. In addition to recovering overpayments, SURS may request a corrective action plan to remedy the billing or programmatic issue identified.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(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 percentage of waiver claims that are paid in accordance with the approved rate methodology. Numerator= Number of waiver claims paid in accordance with the approved rate methodology; Denominator= Total number of paid claims.

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

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 rate changes that are approved by MPSW and consistent with the CMS approved rate methodology. Numerator= Number of rate changes approved by MSPW and consistent with the CMS approved rate methodology; Denominator= Total number of rate changes.

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**

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

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 guidance.

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 systemically 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

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
	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 ROW are initiated by the OCDD with input from a group of interested parties, including but not limited to providers and or provider groups, program participants, advocates,& Medicaid representatives. OCDD's process for developing rates for ROW waiver services is based on rates for similar services in other waivers with review by Medicaid personnel for appropriateness. The overall budget cap for each person in the ROW is established based on his overall (ICAP) score. This allows flexibility for each individual's plan to include an array of services needed within the overall budget cap. If the Medicaid personnel concur that the rates are feasible, can be utilized within the individual's overall budget and represent cost neutrality, then they are submitted to the Medicaid Director as part of the waiver application for final review and approval. Subsequently the reimbursement methodology is included in the Medicaid rulemaking process. This rulemaking process includes further opportunity for public comment. As rates are proposed for each service in the ROW, OCDD presents the rates and service definitions to the Medicaid liaison and other Medicaid representatives as part of the waiver application review.
1.OCDD recommends rates to Medicaid based on the following hierarchy of factors:
a)If there is a comparable service already existing in another OCDD program(i.e.waiver)that rate is mirrored.
b)If there is no existing comparable service,OCDD explores the rates that are compatible with other similar services which are provided by Medicaid (i.e. nursing services).
c)If no comparable Medicaid services and rates exists,OCDD explores services in the general community that are comparable and attempts to match the prevailing competitive rates.
2.Based on the choices available in #1 above, OCDD recommends the service rate to Medicaid where it is reviewed and a determination made of the fiscal impact and budget availability for funding with a final determination made on the service rate.
The ROW budgets follow the ICAP rates which were rebased and are developed within Medicaid. Therefore, the Medicaid Director has not only oversight, but also direct control over the rate determination process.
No rate can be implemented without the approval of the Medicaid Agency.
Rates for each service are based on the following:
*Adult Day Health Care (ADHC): The methodology for calculating each individual component of the overall ADHC rate is a product of the median cost multiplied by an index factor.The resultant calculations provide reasonable and adequate reimbursement required to cover the costs of economic and efficient ADHC services.The base rate is calculated using the most recent audit or desk review cost for all ADHC providers filing acceptable full year cost reports and includes the following components:

a.Direct care-calculated at 115% of the median cost trended forward to rate year;
b. Care related costs-calculated at 105% of the median trended forward to the rate year;
c. Administrative and operating costs-calculated at 105% of the median trended forward to the rate year:
d. Property/capital costs-calculated at the median cost; and
e. Transportation costs-calculated for each provider based on their cost report
The cost report process is conducted yearly.
Because of the wide variation in transportation cost, which is influenced by the rural or urban location of the ADHC center and the number of participants using the ADHC's transportation services versus other means of transportation (e.g. transportation provided by family, etc.), the transportation component of ADHC reimbursement is calculated and paid individually to each ADHC center.Rates may be updated when additional funding is appropriated by the legislature using the most recent audited cost reports at that time. For inflationary increases the state uses various sources of data. For Administrative and operating cost component we use the CPI-All Items (South Region) index and for the Direct Care Cost Component we use the Consumer Price Index-Medical Services (South Region)index.
*Community Living Supports (CLS) and Out-of-Home Respite rates were negotiated based upon the estimated provider cost of rendering the service and similar services as provided in other waivers. The cost of transportation is built into the CLS rate.
When CLS is self-directed, the method of rate determination differs from when the service is provider managed. The provider-managed rate includes a cost component in addition to the rate paid for the services delivered. This additional cost component serves as an "administrative fee" which is payable to the CLS provider for exercising oversight, monitoring, and facilitating an agreement between the CLS provider and CLS worker. This cost component is absent when this service is self-directed. Otherwise, these rates for self-direction are initiated by OCDD and submitted to Medicaid in the same manner and in accordance with the same processes, including opportunity for public comment, as other service rates.
In addition, Factor D charts in Appendix J of the ROW Application reflect a weighted average cost per unit for each year which includes the average of shared rates for Community Living Supports.
*Professional Services and Nursing rates were based upon several factors: the cost to the provider to provide the service, the cost to secure the service out in the community, the cost of similar services in current OCDD contracts, and state payment rates for full time employees.
*Services and rates for dental services were taken from an existing packaged plan of dental services as offered to Medicaid recipients under the EPSDT, Pregnant Woman and Adult Denture programs.
*Louisiana considered the following factors in establishing its ROW day habilitation, prevocational services and supported employment rates as part of its negotiations with providers and with input from other stakeholders: (1) allowances for direct support worker and other staff wages; (2) the provider's overhead costs; (3) transportation costs (per mile) from the vocational agency to all work sites; and (4) a profit margin for the provider.
The rate allowed by the State for supported employment, day habilitation, and pre-vocational services take the following factors into consideration when determining the rate: wages (55%); administrative (10%); overhead, which includes costs for building, equipment, supplies, insurance, and gas (30%); and profit margin (5%). The value of the profit margin is consistent with and comparable to that of similar services provided in the community. The State's estimated profit margin is at 5% of the rate. The value of the administrative and overhead costs are consistent with and comparable to that of similar services provided in the community.
*Transportation rates for Community Access were based on transportation rates payable in other waivers.
*Personal Emergency Response System rates are based on the actual cost of providing the service.
*One Time Transitional Services are paid at the cost of the provision of services with an annual cap. This cap was set based on the historical cost allowed for providing the service in other waivers.
*Environmental Accessibilities Adaptations and Assistive Technology/ Specialized Medical Equipment and Supplies costs are based on historical expenditures for these services in waivers serving similar populations.
*The Companion Care rate is paid to the provider at a daily rate. This rate includes the cost of payment to the Companion worker for services delivered plus an additional cost component payable to the Companion Care provider for oversight, monitoring, and facilitating an agreement between the provider and Companion worker. The rate was based on the limited 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.
*The rates for the Host Home service are graduated according to level of need.The Host Home rates were determined by the increased complexity of the individuals' needs and the associated responsibilities of the Host Home dictated by the score on the ICAP.
*Shared Living and Shared Living-Conversion rates are based on several factors: employee costs, including wages and benefits; indirect costs such as transportation and administration; and staffing requirements and occupancy. All rates are graduated according to the intensity of the need of the individual. The Shared Living rates were determined by the staffing level/ratio required for the increasing acuity level of the individuals being served. The greater the acuity level, the greater the amount of staffing needed. The acuity level was determined by each individual's score on

the ICAP.
The ROW per diem rates and annual budget amounts are calculated based on State Fiscal Year ICAP rates used to determine ICF/DD funding under four acuity levels of recipient needs (intermittent, limited, extensive & pervasive), minus applicable adjustments (provider fees and patient liability). These ROW rates per acuity level are based on each participant's ICAP score and set the overall budget amount (or cap) a ROW participant must fall within when choosing an array of services and tailoring a support plan to meet individual needs. Although the budget amounts set overall caps on expenditures per acuity level, there is much flexibility in choosing individual services which have minimal to no caps placed upon them.
*Support Coordination Services Rate is contracted monthly service rate paid to support coordination providers. The monthly rate is based upon the average service utilization billed. The monthly rate reflects the cost of average units a nationally recognized rate-setting consultant who surveyed providers relative to their time, activities performed, staffing requirements, general administrative and indirect expenses.
• Both Housing Stabilization and Housing Stabilization Transition Service rates are based on the rate paid to support coordination agencies which employ individuals who have obtained a bachelors degree and are qualified to provide two levels of supervisions. An agency trainer or nurse consultant who meets the requirements a support coordinator can also be reimbursed a per quarter rate for services provided. Administrative support, travel and office operating expenses are included in the 15 minute billing rate.
OCDD's process for developing rates for ADHC waiver services is based on rates for similar services in other waivers with review by Medicaid personnel for appropriateness.If Medicaid personnel concur that the rates are feasible and will help facilitate cost neutrality, then they are submitted to the Medicaid Director as part of the waiver application for final review and approval. Subsequently, the reimbursement methodology is included in the Medicaid rulemaking process. This rulemaking process includes further opportunity for public comment.
All proposed rates are then factored into a cost projection and model to produce and estimated total program cost and average cost per recipient which is then used to determine the effects of these rates on program cost effectiveness. Rates are then renegotiated or changed as needed.
Payment rates are available to participants through provider agencies, support coordinators and agencies, as well as through publication in the Louisiana Register, the official journal for the state of Louisiana. Participants may also receive information on service rates by contacting their OCDD Local Governing Entity (LGE). OCDD solicited public input from recipients, providers, and advocacy organizations to determine rate, structure methodology, etc. This is accomplished through meetings with these entities around the state.

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

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

Appendix I: Financial Accountability

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

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

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

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

Select at least one:

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

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured 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.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [x] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

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

  A fiscal/employer agent will provide fiscal management services to Self-Direction participants, as an administrative activity. Payments will be made to employees for direct services to the waiver self-direction participants related to the service Community Living Supports. The fiscal/employer agent will process participants' employer-related payroll and withhold and deposit the required employment-related taxes.

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

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

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

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

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

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 ROW waiver participants and will be paid for those services. Those ROW services will include shared living, supported employment, prevocational services, day habilitation, and professional services. These waiver services delivered by the Regional Service Centers are not located in institutional-based settings.

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.**
- ( ) **This waiver is a part of a concurrent □1115/□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 □1115 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*:

- [x] **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:

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

Appendix I: Financial Accountability

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

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

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

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

Appendix I: Financial Accountability

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

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

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

i. Co-Pay Arrangement.

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

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

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

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 Column 4)
1	36057.15	17693.00	53750.15	85268.00	5111.00	90379.00	36628.85
2	36614.60	17693.00	54307.60	85268.00	5111.00	90379.00	36071.40
3	50052.21	17693.00	67745.21	85268.00	5111.00	90379.00	22633.79
4	40252.42	10965.00	51217.42	79312.00	4021.00	83333.00	32115.58
5	43638.56	10965.00	54603.56	79312.00	4021.00	83333.00	28729.44

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	625		625	
Year 2	725		725	
Year 3	825		825	
Year 4	925		925	
Year 5	1025		1025	

Appendix J: Cost Neutrality Demonstration

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

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

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

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

The factor D and D' prime estimates for WY 1-5 were based on data drawn from the state's Medicaid data warehouse for the anticipated population that would be eligible for transfer in addition to information for the existing ROW participants. The following data and sources were used:

- Historical utilization and expenditure data for ADHC services.
- Historical utilization and expenditure data for personal care assistance services under CCW
- Historical utilization and expenditure data for state plan personal care services
- Historical utilization and expenditure data for support coordination services

Appendix J: Cost Neutrality Demonstration

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

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

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

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

An estimated cost per service is derived by multiplying these estimates by actual service rates. This dollar amount is then totaled and divided by the number of unduplicated recipients for an average cost per recipient. A utilization inflation factor is thereby applied to each subsequent year based on program history and assumptions based on best professional judgment.
Factors D and D' were derived from two data sources. The first source is the ROW 372 Report for 2016-2017. All of the existing ROW services were based on our Part X addendum for the 372 report that gives utilization data the feeds into the other sections of the standard report. For the individuals transferring to the ROW, data was used from the Medicaid MARS Data Warehouse. Utilization data was collected for a 24 month period starting July 2015 to June 2017 for the ADHC services, personal care assistance services, state plan personal care services, and support coordination services.

ADHC Service - The state looked at 24 months of claims data for the identified ADHC persons who were possible transfers to the ROW. The time period analyzed was LDH state fiscal years 2015 to 2017. The source of this information was the Medicaid MARS Data Warehouse

Personal care assistance services under CCW for those persons transitioning to ROW. -The state looked at 24 months of claims data for the identified OAAS-CCW persons who were possible transfers to the ROW. The time period analyzed was LDH state fiscal years 2015 to 2017. The source of this information was the Medicaid MARS Data Warehouse.

Historical utilization and expenditure data for state plan personal care services - The state looked at 24 months of state long-term personal care service claims data for the identified ADHC and OAAS-CCW persons who were possible transfers to the ROW. The time period analyzed was LDH state fiscal years 2015 to 2017. The source of this information was the Medicaid MARS Data Warehouse.

Historical utilization and expenditure data for support coordination services.The state looked at 24 months of support coordination claims data for the identified ADHC and OAAS-CCW persons who were possible transfers to the ROW. The time period analyzed was LDH state fiscal years 2015 to 2017. The source of this information was the Medicaid MARS Data Warehouse. Support Coordination services for persons in the ADHC waiver and the Community Choices Waiver are paid on a monthly basis. Support Coordination services in the ROW are paid in 15 minute increments. Since there was no one to one service equivalent, some assumptions had to be made as to how many 15 minute service units are actually used in the monthly rate of the ADHC and Community Choices Waivers. That estimated number of units was then added to the total units identified on Part X per ROW recipient and then divided by the estimated number of ROW unduplicated recipients to get the average number of units of service. That number was then multiplied by the cost per service to get the estimated total cost.

• 2015-2017 CMS 372 report for the ROW

The state uses an in-state only document called Part X addendum to the annual CMS 372 report to estimate the utilization for ROW services. This sheet is not required by CMS and is not included with the submitted report. It creates a recipient, services, and payment by procedure code for each ROW service that is the basis for the numbers reported in the actual 372 report.

For Community Living Supports, the state used MARS Data Warehouse data for the previously mentioned 24 month period to estimate the total number of personal care units (PCA and PCS) used by the persons projected to be transferred from the ADHC and Community Choice Waivers. A historical monthly average utilization rate was calculated per person and then multiplied by the number of persons transferring to get a total number of units for the transferring group. The total units were then added to the total number of units identified on the Part X report and divided by the new estimated number of unduplicated recipients to get an average number of units per recipient. That number was then multiplied by the cost per service to get the estimated total cost.

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

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

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

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

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

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

Factor G is an estimate based on the actual Medicaid expenditures for all private intermediate care facilities for individuals with developmental disabilities (ICF/DD). This dollar amount is totaled and then divided by the number of waiver participants to get an estimated average cost. A utilization inflation factor is thereby applied to each subsequent year based on program history and other factors. 2015-2017 372 reports is the source for the state's estimates.

The factor D and D' prime estimates for WY 3-5 were based on data drawn from the state's Medicaid data warehouse for the anticipated population that would be eligible for transfer in addition to information for the existing ROW participants. The following data and sources were used:

- Historical utilization and expenditure data for ADHC services.
- Historical utilization and expenditure data for personal care assistance services under CCW
- Historical utilization and expenditure data for state plan personal care services
- Historical utilization and expenditure data for support coordination services

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 individuals with developmental disabilities (ICF/DD). This dollar amount is totaled and then divided by the number of waiver participants to get an estimated average cost. A utilization inflation factor is thereby applied to each subsequent year based on program history and other factors. 2016-2017 372 reports are the source for the state's estimates. These "other factors" refer to assumptions based on best professional judgement.

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

Appendix J: Cost Neutrality Demonstration

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

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

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

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:						**1932339.08**
Adult Day Health Care	15 minutes	131	5306.00	2.78	**1932339.08**	
Day Habilitation Total:						**358345.00**
Day Habilitation	2.5 hours	65	298.00	18.50	**358345.00**	
Prevocational Services Total:						**254160.00**
Prevocational Services	2.5 hours	32	353.00	22.50	**254160.00**	
Respite Services - Out of Home Total:						**779.76**
Respite Services - Out of Home	15 minutes	9	24.00	3.61	**779.76**	
Shared Living Services Total:						**553117.50**
Shared Living Services	Per Diem	31	305.00	58.50	**553117.50**	
Support Coordination Total:						**869550.00**
Support Coordination	Monthly	625	11.00	126.48	**869550.00**	
Supported Employment Total:						**17638.40**
Supported Employment	15 minutes	32	212.00	2.60	**17638.40**	
Assistive Technology/Specialized Medical Equipment and Supplies Total:						**462.00**
Assistive Technology/Specialized Medical Equipment and Supplies	Per Item	2	1.00	231.00	**462.00**	
Dental Total:						**1589.49**
Dental	Per Procedure	9	3.00	58.87	**1589.49**	
Community Living Supports Total:						**14818818.96**
Community Living Supports	15 minutes	438	9372.00	3.61	**14818818.96**	
Companion Care Total:						**3157206.20**
Companion Care	Per Diem	94	365.00	92.02	**3157206.20**	
Environmental Accessibility Adaptations Total:						**111943.35**
Environmental Accessibility Adaptations	Per Item	9	3.00	4146.05	**111943.35**	
				GRAND TOTAL:		**22535718.59**
				Total Estimated Unduplicated Participants:		**625**
				Factor D (Divide total by number of participants):		**36057.15**
				Average Length of Stay on the Waiver:		356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Host Home Total:						**3461.85**
Host Home	Per Diem	63	1.00	54.95	**3461.85**	
Housing Stabilization Service Total:						**936.82**
Housing Stabilization Service	15 minutes	2	31.00	15.11	**936.82**	
Housing Stabilization Transition Service Total:						**1873.64**
Housing Stabilization Transition Service	15 minutes	2	62.00	15.11	**1873.64**	
Nursing Total:						**353781.22**
Nursing	15 minutes	26	1703.00	7.99	**353781.22**	
One-Time Transitional Services Total:						**51000.00**
One-Time Transitional Services	Per Package	17	1.00	3000.00	**51000.00**	
Personal Emergency Response System Total:						**27699.60**
Personal Emergency Response System	Monthly	82	12.00	28.15	**27699.60**	
Professional Services Total:						**18306.00**
Physical Therapy	15 minutes	9	24.00	13.75	**2970.00**	
Licensed Clinical Social Work	15 minutes	9	24.00	7.50	**1620.00**	
Registered Dietician	15 minutes	9	24.00	9.00	**1944.00**	
Speech Therapy	15 minutes	9	24.00	11.25	**2430.00**	
Occupational Therapy	15 minutes	9	24.00	12.00	**2592.00**	
Psychology	15 minutes	9	24.00	31.25	**6750.00**	
Transportation - Community Access Total:						**2709.72**
Transportation - Community Access	One-way trip	9	52.00	5.79	**2709.72**	
			GRAND TOTAL:			**22535718.59**
			Total Estimated Unduplicated Participants:			**625**
			Factor D (Divide total by number of participants):			**36057.15**
			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
Adult Day Health Care Total:						**2242103.36**
Adult Day Health Care	15 minutes	152	5306.00	2.78	**2242103.36**	
Day Habilitation Total:						**413475.00**
Day Habilitation	2.5 hours	75	298.00	18.50	**413475.00**	
Prevocational Services Total:						**293872.50**
Prevocational Services	2.5 hours	37	353.00	22.50	**293872.50**	
Respite Services - Out of Home Total:						**926.40**
Respite Services - Out of Home	15 minutes	10	24.00	3.86	**926.40**	
Shared Living Services Total:						**642330.00**
Shared Living Services	Per Diem	36	305.00	58.50	**642330.00**	
Support Coordination Total:						**1008678.00**
Support Coordination	Monthly	725	11.00	126.48	**1008678.00**	
Supported Employment Total:						**20394.40**
Supported Employment	15 minutes	37	212.00	2.60	**20394.40**	
Assistive Technology/Specialized Medical Equipment and Supplies Total:						**924.00**
Assistive Technology/Specialized Medical Equipment and Supplies	Per Item	2	2.00	231.00	**924.00**	
Dental Total:						**1766.10**
Dental	Per Procedure	10	3.00	58.87	**1766.10**	
Community Living Supports Total:						**17605248.00**
Community Living Supports	15 minutes	508	9600.00	3.61	**17605248.00**	
Companion Care Total:						**3661015.70**

GRAND TOTAL:	**26545587.67**
Total Estimated Unduplicated Participants:	**725**
Factor D (Divide total by number of participants):	**36614.60**
Average Length of Stay on the Waiver:	356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Companion Care	Per Diem	109	365.00	92.02	3661015.70	
Environmental Accessibility Adaptations Total:						124381.50
Environmental Accessibility Adaptations	Per Item	10	3.00	4146.05	124381.50	
Host Home Total:						4011.35
Host Home	Per Diem	73	1.00	54.95	4011.35	
Housing Stabilization Service Total:						936.82
Housing Stabilization Service	15 minutes	2	31.00	15.11	936.82	
Housing Stabilization Transition Service Total:						1873.64
Housing Stabilization Transition Service	15 minutes	2	62.00	15.11	1873.64	
Nursing Total:						408209.10
Nursing	15 minutes	30	1703.00	7.99	408209.10	
One-Time Transitional Services Total:						60000.00
One-Time Transitional Services	Per Package	20	1.00	3000.00	60000.00	
Personal Emergency Response System Total:						32091.00
Personal Emergency Response System	Monthly	95	12.00	28.15	32091.00	
Professional Services Total:						20340.00
Physical Therapy	15 minutes	10	24.00	13.75	3300.00	
Licensed Clinical Social Work	15 minutes	10	24.00	7.50	1800.00	
Registered Dietician	15 minutes	10	24.00	9.00	2160.00	
Speech Therapy	15 minutes	10	24.00	11.25	2700.00	
Occupational Therapy	15 minutes	10	24.00	12.00	2880.00	
Psychology	15 minutes	10	24.00	31.25	7500.00	
Transportation - Community Access Total:						3010.80
Transportation - Community Access	One-way trip	10	52.00	5.79	3010.80	
				GRAND TOTAL:		26545587.67
				Total Estimated Unduplicated Participants:		725
				Factor D (Divide total by number of participants):		36614.60
				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
Adult Day Health Care Total:						2551867.64
Adult Day Health Care	15 minutes	173	5306.00	2.78	2551867.64	
Day Habilitation Total:						474118.00
Day Habilitation	2 5 hours	86	298.00	18.50	474118.00	
Prevocational Services Total:						333585.00
Prevocational Services	2 5 hours	42	353.00	22.50	333585.00	
Respite Services - Out of Home Total:						1111.68
Respite Services - Out of Home	15 minutes	12	24.00	3.86	1111.68	
Shared Living Services Total:						731542.50
Shared Living Services	Per Diem	41	305.00	58.50	731542.50	
Support Coordination Total:						10747638.00
Support Coordination	Monthly	825	103.00	126.48	10747638.00	
Supported Employment Total:						23150.40
Supported Employment	15 minutes	42	212.00	2.60	23150.40	
Assistive Technology/Specialized Medical Equipment and Supplies Total:						1386.00
Assistive Technology/Specialized Medical Equipment and Supplies	Per Item	3	2.00	231.00	1386.00	
Dental Total:						2119.32
Dental	Per Procedure	12	3.00	58.87	2119.32	
				GRAND TOTAL:		41293071.64
				Total Estimated Unduplicated Participants:		825
				Factor D (Divide total by number of participants):		50052.21
				Average Length of Stay on the Waiver:		356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Living Supports Total:						**21510553.22**
Community Living Supports	15 minutes	578	10309.00	3.61	21510553.22	
Companion Care Total:						**4164825.20**
Companion Care	Per Diem	124	365.00	92.02	4164825.20	
Environmental Accessibility Adaptations Total:						**149257.80**
Environmental Accessibility Adaptations	Per Item	12	3.00	4146.05	149257.80	
Host Home Total:						**4560.85**
Host Home	Per Item	83	1.00	54.95	4560.85	
Housing Stabilization Service Total:						**1405.23**
Housing Stabilization Service	15 minutes	3	31.00	15.11	1405.23	
Housing Stabilization Transition Service Total:						**2810.46**
Housing Stabilization Transition Service	15 minutes	3	62.00	15.11	2810.46	
Nursing Total:						**462636.98**
Nursing	15 Minutes	34	1703.00	7.99	462636.98	
One-Time Transitional Services Total:						**66000.00**
One-Time Transitional Services	Per Package	22	1.00	3000.00	66000.00	
Personal Emergency Response System Total:						**36482.40**
Personal Emergency Response System	Monthly	108	12.00	28.15	36482.40	
Professional Services Total:						**24408.00**
Physical Therapy	15 minutes	12	24.00	13.75	3960.00	
Licensed Clinical Social Work	15 minutes	12	24.00	7.50	2160.00	
Registered Dietician	15 minutes	12	24.00	9.00	2592.00	
Speech Therapy	15 minutes	12	24.00	11.25	3240.00	
Occupational Therapy	15 minutes	12	24.00	12.00	3456.00	
Psychology					9000.00	

GRAND TOTAL:	**41293071.64**
Total Estimated Unduplicated Participants:	**825**
Factor D (Divide total by number of participants):	**50052.21**
Average Length of Stay on the Waiver:	356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 minutes	12	24.00	31.25		
Transportation - Community Access Total:						**3612.96**
Transportation - Community Access	One-way trip	12	52.00	5.79	**3612.96**	
				GRAND TOTAL:		**4129307164**
				Total Estimated Unduplicated Participants:		**825**
				Factor D (Divide total by number of participants):		**5005221**
				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
Adult Day Health Care Total:						**2861631.92**
Adult Day Health Care	15 minutes	194	5306.00	2.78	**2861631.92**	
Day Habilitation Total:						**529248.00**
Day Habilitation	2.5 hours	96	298.00	18.50	**529248.00**	
Prevocational Services Total:						**373297.50**
Prevocational Services	2.5 hours	47	353.00	22.50	**373297.50**	
Respite Services - Out of Home Total:						**1204.32**
Respite Services - Out of Home	15 minutes	13	24.00	3.86	**1204.32**	
Shared Living Services Total:						**820755.00**
Shared Living Services	Per Diem	46	305.00	58.50	**820755.00**	
Support Coordination Total:						**1286934.00**
Support Coordination	15 minutes	925	11.00	126.48	**1286934.00**	
Supported Employment Total:						**25906.40**
				GRAND TOTAL:		**37233491.66**
				Total Estimated Unduplicated Participants:		**925**
				Factor D (Divide total by number of participants):		**40252.42**
				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	15 minutes	47	212.00	2.60	25906.40	
Assistive Technology/Specialized Medical Equipment and Supplies Total:						3616.00
Assistive Technology/Specialized Medical Equipment and Supplies	Per Item	2	2.00	904.00	3616.00	
Dental Total:						2295.93
Dental	Per Procedure	13	3.00	58.87	2295.93	
Community Living Supports Total:						25825651.20
Community Living Supports	15 minutes	648	11040.00	3.61	25825651.20	
Companion Care Total:						4668634.70
Companion Care	Per Diem	139	365.00	92.02	4668634.70	
Environmental Accessibility Adaptations Total:						161695.95
Environmental Accessibility Adaptations	Per Item	13	3.00	4146.05	161695.95	
Host Home Total:						5110.35
Host Home	Per Diem	93	1.00	54.95	5110.35	
Housing Stabilization Service Total:						1405.23
Housing Stabilization Service	15 minutes	3	31.00	15.11	1405.23	
Housing Stabilization Transition Service Total:						2810.46
Housing Stabilization Transition Service	15 minutes	3	62.00	15.11	2810.46	
Nursing Total:						517064.86
Nursing	15 minutes	38	1703.00	7.99	517064.86	
One-Time Transitional Services Total:						75000.00
One-Time Transitional Services	Per Package	25	1.00	3000.00	75000.00	
Personal Emergency Response System Total:						40873.80
Personal Emergency Response System	Monthly	121	12.00	28.15	40873.80	
Professional Services Total:						26442.00
			GRAND TOTAL:			37233491.66
			Total Estimated Unduplicated Participants:			925
			Factor D (Divide total by number of participants):			40252.42
			Average Length of Stay on the Waiver:			356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Physical Therapy	15 minutes	13	24.00	13.75	4290.00	
Licensed Clinical Social Work	15 minutes	13	24.00	7.50	2340.00	
Registered Dietician	15 minutes	13	24.00	9.00	2808.00	
Speech Therapy	15 minutes	13	24.00	11.25	3510.00	
Occupational Therapy	15 minutes	13	24.00	12.00	3744.00	
Psychology	15 minutes	13	24.00	31.25	9750.00	
Transportation - Community Access Total:						3914.04
Transportation - Community Access	One-way trip	13	52.00	5.79	3914.04	
				GRAND TOTAL:		37233491.66
				Total Estimated Unduplicated Participants:		925
				Factor D (Divide total by number of participants):		40252.42
				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
Adult Day Health Care Total:						3171396.20
Adult Day Health Care	15 minutes	215	5306.00	2.78	3171396.20	
Day Habilitation Total:						589891.00
Day Habilitation	2 5 hours	107	298.00	18.50	589891.00	
Prevocational Services Total:						413010.00
Prevocational Services	2 5 hours	52	353.00	22.50	413010.00	
Respite Services - Out of Home Total:						1389.60
					1389.60	
				GRAND TOTAL:		44729527.55
				Total Estimated Unduplicated Participants:		1025
				Factor D (Divide total by number of participants):		43638.56
				Average Length of Stay on the Waiver:		356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Services - Out of Home	15 minutes	15	24.00	3.86		
Shared Living Services Total:						**909967.50**
Shared Living Services	Per Diem	51	305.00	58.50	**909967.50**	
Support Coordination Total:						**1426062.00**
Support Coordination	Monthly	1025	11.00	126.48	**1426062.00**	
Supported Employment Total:						**28662.40**
Supported Employment	15 minutes	52	212.00	2.60	**28662.40**	
Assistive Technology/Specialized Medical Equipment and Supplies Total:						**5424.00**
Assistive Technology/Specialized Medical Equipment and Supplies	Per Item	3	2.00	904.00	**5424.00**	
Dental Total:						**2649.15**
Dental	Per Procedure	15	3.00	58.87	**2649.15**	
Community Living Supports Total:						**32062792.60**
Community Living Supports	15 minutes	718	12370.00	3.61	**32062792.60**	
Companion Care Total:						**5172444.20**
Companion Care	Per Diem	154	365.00	92.02	**5172444.20**	
Environmental Accessibility Adaptations Total:						**186572.25**
Environmental Accessibility Adaptations	Per Item	15	3.00	4146.05	**186572.25**	
Host Home Total:						**5659.85**
Host Home	Per Diem	103	1.00	54.95	**5659.85**	
Housing Stabilization Service Total:						**1405.23**
Housing Stabilization Service	15 minutes	3	31.00	15.11	**1405.23**	
Housing Stabilization Transition Service Total:						**2810.46**
Housing Stabilization Transition Service	15 minutes	3	62.00	15.11	**2810.46**	
Nursing Total:						**585099.71**

GRAND TOTAL:	**44729527.55**
Total Estimated Unduplicated Participants:	**1025**
Factor D (Divide total by number of participants):	**43638.56**
Average Length of Stay on the Waiver:	356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nursing	15 minutes	43	1703.00	7.99	585099.71	
One-Time Transitional Services Total:						84000.00
One-Time Transitional Services	Per Package	28	1.00	3000.00	84000.00	
Personal Emergency Response System Total:						45265.20
Personal Emergency Response System	Monthly	134	12.00	28.15	45265.20	
Professional Services Total:						30510.00
Physical Therapy	15 minutes	15	24.00	13.75	4950.00	
Licensed Clinical Social Work	15 minutes	15	24.00	7.50	2700.00	
Registered Dietician	15 minutes	15	24.00	9.00	3240.00	
Speech Therapy	15 minutes	15	24.00	11.25	4050.00	
Occupational Therapy	15 minutes	15	24.00	12.00	4320.00	
Psychology	15 minutes	15	24.00	31.25	11250.00	
Transportation - Community Access Total:						4516.20
Transportation - Community Access	One-way trip	15	52.00	5.79	4516.20	

GRAND TOTAL:	44729527.55
Total Estimated Unduplicated Participants:	1025
Factor D (Divide total by number of participants):	43638.56
Average Length of Stay on the Waiver:	356