☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

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

Data Aggregation and Analysis:

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

Performance Measure:
G.a.i.a.4. Number and percentage of critical incidents where all necessary follow-up was completed and appropriate actions were taken as measured by closure of the critical incident. Numerator = Number of critical incidents where all follow-up was completed and appropriate actions 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:
Online Tracking Incident System (OTIS)

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

	✓ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

	Specify:	

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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 = 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

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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.

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.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Remediation for all performance indicators except for G.a.i.a.5 is tracked within the Online tracking Incident System (OTIS) and LOC/POC databases. OCDD runs quarterly reports for critical incidents. OCDD runs complaints and LOC/POC reports annually.

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

preventable. But we review all deaths to identify those for which provider corrective actions are needed and to identify trends and patterns that may require quality improvement initiative such as the training on signs and symptoms of illness for provider agencies.

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

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 OIS* and revise it as necessary and appropriate.

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

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

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

Direct Service Provider and Support Coordination Agency Processes:

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

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

• OCDD Regional Waiver Supports and Services Office or Human Services Authority or District is also required to have a Quality Management Strategy. They are required to collect information on performance indicators, conduct remediation as needed, aggregate data and review to identify trends and patterns and areas in which improvement is needed, and prioritize needed improvements. They are required to design and implement quality enhancement strategies and evaluate the effectiveness of those strategies. Each OCDD Regional Waiver Supports and Services Office or Human Services Authority or District has a Quality Specialist whose function is to facilitate data analysis and review and a Regional Office Specialist whose function is to provide training and technical assistance to Support Coordination and Direct Service Provider Agencies. Within each Regional Waiver Supports and Services Office or Human Services Authority or District, data review will be conducted by programmatic and management staff and by the Regional Advisory Committee which is composed of stakeholders. OCDD State Office staff visit each region, Human Services Authority or District annually to validate the quarterly data reported to OCDD State Office on performance indicators, to assure that remediation and system improvements occur as needed, and to provide technical assistance.

OCDD State Office Processes:

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

• Remediation for individual cases (e.g., from individual critical incidents reports, complaints reports, supervisory case record reviews, etc.) is identified by Regional Supports and Services Waiver Office or Human Services Authority or District staff and OCDD State Office Programmatic staff. Remediation reports are reviewed by the OCDD Performance Review Committee to identify trends and patterns and to assure timely corrective action.

• Regional Office performance indicators are integrated into the entire QMS for the waiver. The paid service provider and Support Coordination agency strategies are not integrated into the entire QMS, nor the waiver because they serve multiple waiver and Medicaid targeted populations.

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

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

Cross-Waiver Stakeholder Advisory Committee – Meets twice a year. Members include Waiver Compliance Section of the state Medicaid agency (WCS), Adult Protective Services (APS), state operating agencies (Office for Citizens with Developmental Disabilities and Office of Aging Supports and Services) agencies, consumers, providers, and advocates. The mission of the group is to:
• Assure that decisions with respect to HCBS waivers are informed by the diversity of perspectives and experiences of HCBS participants and other stakeholders.
• Identify or update measures for assessing HCBS waiver quality
• Evaluate performance data against adopted measures
• Advise on quality improvement initiatives
• Help integrate quality initiatives with other public/private efforts
• Review and comment on public performance reports
-Communicate results of QIS activities stratified by waiver, to agencies, waiver providers, participants, families and other interested parties, and the public annually

Cross-Waiver Executive Management Team– Meets quarterly. Members include Assistant Secretaries & Section Chiefs/Division Directors of OAAS, OCDD, and WCS & HSS. The mission of the group is to:
• Oversee the performance of HCBS waivers to assure their effectiveness, efficiency and integration.
• Adopt quality standards and measures for HCBS waivers.
• Evaluate performance reports on a scheduled basis.
• Take action on recommendations from Advisory Group Cross Waiver Quality Team/Workgroups.
• Establish priorities and allocate resources
• Establish workgroups to design, coordinate and integrate improvement strategies.
• Trouble shoot critical issues

Cross-Waiver Quality Review Team – Meets every other month. The team is composed of quality, programmatic & IT information technology representatives from the Program Offices, Medicaid and DHH IT. The Cross-Waiver Quality Review Team reports to the Cross-Waiver Executive Management Team. The mission of this group is to:
• Integrate and align HCBS waiver policies, practices and tools to assure maximum effectiveness and efficiency. Review draft policies, CMS applications/renewals, contracts/agreements and reports related to HCBS waivers to assure consistency with quality standards.
• Identify opportunities for coordinating, integrating and consolidating waiver activities and functions.
• Share information and knowledge regarding best and promising practices.
• Design, generate and review comparative performance reports.
• Standing agenda items for this team include continuous collaboration on joint policy whenever possible for rules, issues, and policies for Support Coordination, Direct Service Providers and Critical Incident Reporting

ii. System Improvement Activities

Responsible Party(check each that applies):	Frequency of Monitoring and Analysis(check each that applies):
✓ State Medicaid Agency	☐ Weekly
✓ Operating Agency	☐ Monthly
☐ Sub-State Entity	✓ Quarterly
☐ Quality Improvement Committee	✓ Annually
☐ Other Specify:	☐ Other Specify:

b. System Design Changes

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

OCDD Process:

• Following system design changes, data on performance indicators are reviewed by the OCDD Performance Review Committee to assure that the information is useful and accurate and to determine if performance has improved. Input is sought, as appropriate, from Support Coordination and Direct Service Provider Agencies, participants and their families, and other stakeholders, to determine whether the system design change is helping to improve efficiency and effectiveness of waiver supports and services.

BHSF Processes:

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

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

OCDD Process:

• Evaluation of the Quality Improvement Strategy occurs on an ongoing basis as data from discovery methods are entered into databases and reports of aggregate data are analyzed for trends and patterns. Questions are considered such as: Is the data useful? Is the frequency of data analyses appropriate? Are the right persons involved in the review of data reports? Reports of Quality Improvement activities are communicated to agencies such as the DD Council and State Advisory Committee.

BHSF Processes:

• Based on the reviews of the OCDD quarterly reports from OCDD regarding recommendations, performance indicator data reports, and quality improvement initiatives status reports, summary reports regarding provider agency and regional office quality management strategy implementation, and other data that will be examined monthly to assess the status of the waiver assurances, along with quarterly examination of redesign, BHSF will be able to evaluate the effectiveness of the QIS on a continuing basis in preparation for the annual report due the Medicaid Director.

• A more formal review will occur on an annual basis by BHSF in collaboration with OCDD. The BHSF and OCDD will evaluate components of the quality improvement strategy including performance indicators, discovery methods, remediation strategies, databases, data aggregation and review processes etc. to determine if revisions are appropriate.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

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

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

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

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
I.a.1. Number and percentage of waiver services provided to participants who were enrolled in the waiver on the date the service was reported as delivered. Percentage = Number of waiver services provided to participants who were enrolled in the waiver on the date the service was reported as delivered / Total number of waiver services reported as delivered.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
I.a.2. Number and percentage of waiver claims submitted which did not exceed the approved rate. Percentage = Number of submitted waiver claims which did not exceed the approved rate / Total number of paid claims.

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

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

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
BHSF reviews reports on aberrant billing practices and provider enrollment on a monthly basis to identify areas of non-compliance, determine if the results indicate there are on-going or systematic problems, and determine remediation actions needed. Remediation action is taken by the SMA if systemic problems are identifed. The entities responsible for remediation actions include the data contractor and the contracted fiscal intermediary. The SMA meets with the contractor to determine how the problem occurred and to implement steps to correct the problem. These actions are tracked via the Louisiana Medicaid Management Information System. The SMA may impose monetary penalties depending on the type of problem identified.

ii. **Remediation Data Aggregation**

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

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

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

c. Timelines

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

- ◉ **No**
- ○ **Yes**

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

Appendix I: Financial Accountability

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

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

Rates for the ROW are initiated by the Office of Citizens with Developmental Disabilities (OCDD) with input from a group of interested parties, including but not limited to providers and or provider groups, program participants, advocates, and Medicaid representatives. OCDD's process for developing rates for ROW waiver services is based on rates for similar services in other waivers with review by Medicaid personnel for appropriateness. The overall budget cap for each person in the ROW is established based on his overall Inventory for Client and Agency Planning (ICAP) score. This allows flexibility for each individual's plan to include an array of services needed within the overall budget cap. If the Medicaid personnel concur that the rates are feasible, can be utilized within the individual's overall budget and represent cost neutrality, then they are submitted to the Medicaid Director as part of the waiver application for final review and approval. Subsequently the reimbursement methodology is included in the Medicaid rulemaking process. This rulemaking process includes further opportunity for public comment.

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

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

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

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

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

Rates for each service are based on the following:

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

When CLS is self-directed, the method of rate determination differs from when the service is provider managed. The provider-managed rate includes a cost component in addition to the rate paid for the services delivered. This additional cost component serves as an "administrative fee" which is payable to the CLS provider for exercising oversight, monitoring, and facilitating an agreement between the CLS provider and CLS worker. This cost component is absent when this service is self-directed. Otherwise, these rates for self-direction are initiated by OCDD and submitted to Medicaid in the same manner and in accordance with the same processes, including opportunity for public comment, as other service rates.

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

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

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

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

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

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

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

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

* The Companion Care rate is paid to the provider at a daily rate. This rate includes the cost of payment to the Companion worker for services delivered plus an additional cost component payable to the Companion Care provider for oversight, monitoring, and facilitating an agreement between the provider and Companion worker. The rate was based on the limited 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 a conversion of the former contracted monthly service rate paid to support coordination providers into a rate based on 15 minute increments. The conversion utilized a nationally recognized rate-setting consultant who surveyed providers relative to their time, activities performed, staffing requirements, general administrative and indirect expenses to

develop a model for achieving the 15 minute increment rate.

• Both Housing Stabilization and Housing Stabilization Transition Service rates are based on the rate paid to support coordination agencies which employ individuals who have obtained a bachelors degree and are qualified to provide two levels of supervisions. An agency trainer or nurse consultant who meets the requirements a support coordinator can also be reimbursed a per quarter rate for services provided. Administrative support, travel and office operating expenses are included in the 15 minute billing rate. OCCD'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.**
- ☑ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☑ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

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

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

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.**

Appendix I: Financial Accountability

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

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

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

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

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

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

Appendix I: Financial Accountability

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

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

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

Check each that applies:

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

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an

Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

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

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

Appendix I: Financial Accountability

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

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

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

○ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

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

Appendix I: Financial Accountability

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

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

○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

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

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 Column4)
1	25961.26	17693.00	43654.26	85268.00	5111.00	90379.00	46724.74
2	26567.50	17693.00	44260.50	85268.00	5111.00	90379.00	46118.50
3	33192.71	10965.00	44157.71	80281.00	4064.00	84345.00	40187.29
4	34330.76	10965.00	45295.76	80281.00	4064.00	84345.00	39049.24
5	35843.63	10965.00	46808.63	80281.00	4064.00	84345.00	37536.37

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	225	225
Year 2	325	325
Year 3	325	325
Year 4	325	325
Year 5	350	350

Appendix J: Cost Neutrality Demonstration

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

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

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

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

Appendix J: Cost Neutrality Demonstration

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

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

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

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

An estimated cost per service is derived by multiplying these estimates by actual service rates. This dollar amount is then totaled and divided by the number of unduplicated recipients for an average cost per recipient. A utilization inflation factor is thereby applied to each subsequent year based on program history and assumptions based on best professional judgment.

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

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

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

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

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

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

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

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. 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	

Waiver Services	
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:						0.00
Adult Day Health Care	15 minutes	0	0.00	2.78	0.00	
Day Habilitation Total:						165390.00
Day Habilitation	2.5 hours	30	298.00	18.50	165390.00	
Prevocational Services Total:						119137.50
Prevocational Services	2.5 hours	15	353.00	22.50	119137.50	
Respite Services - Out of Home Total:						370.56
Respite Services - Out of Home	15 minutes	4	24.00	3.86	370.56	
Shared Living Services Total:						1784250.00
Shared Living Services	Per Diem	100	305.00	58.50	1784250.00	
Support Coordination Total:						431055.00
Support Coordination	15 minutes	225	103.00	18.60	431055.00	
Supported Employment Total:						8268.00
Supported Employment	15 minutes	15	212.00	2.60	8268.00	
Assistive Technology/Specialized Medical Equipment and Supplies Total:						924.00
			GRAND TOTAL:			5841283.37
			Total Estimated Unduplicated Participants:			225
			Factor D (Divide total by number of participants):			25961.26
			Average Length of Stay on the Waiver:			356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology/Specialized Medical Equipment and Supplies	Per Item	4	1.00	231.00	924.00	
Dental Total:						706.44
Dental	Per Procedure	4	3.00	58.87	706.44	
Community Living Supports Total:						2959795.68
Community Living Supports	15 minutes	48	17081.00	3.61	2959795.68	
Companion Care Total:						119720.00
Companion Care	Per Diem	8	365.00	41.00	119720.00	
Environmental Accessibility Adaptations Total:						49752.60
Environmental Accessibility Adaptations	Per Item	4	3.00	4146.05	49752.60	
Host Home Total:						3791.55
Host Home	Per Diem	69	1.00	54.95	3791.55	
Housing Stabilization Service Total:						0.00
Housing Stabilization Service	15 minutes	0	0.00	15.11	0.00	
Housing Stabilization Transition Service Total:						0.00
Housing Stabilization Transition Service	15 minutes	0	0.00	15.11	0.00	
Nursing Total:						163283.64
Nursing	15 minutes	12	1703.00	7.99	163283.64	
One-Time Transitional Services Total:						24000.00
One-Time Transitional Services	Per Package	8	1.00	3000.00	24000.00	
Personal Emergency Response System Total:						2702.40
Personal Emergency Response System	Monthly	8	12.00	28.15	2702.40	
Professional Services Total:						8136.00
Licensed Clinical Social Work	15 minutes	4	24.00	7.50	720.00	
Registered Dietician	15 minutes	4	24.00	9.00	864.00	
Occupational Therapy	15 minutes	4	24.00	12.00	1152.00	
Speech Therapy	15 minutes	4	24.00	11.25	1080.00	
Psychology	15 minutes	4	24.00	31.25	3000.00	
Physical Therapy	15 minutes	4	24.00	13.75	1320.00	
Transportation - Community Access Total:						0.00
Transportation - Community Access					0.00	

GRAND TOTAL:	5841283.37
Total Estimated Unduplicated Participants:	225
Factor D (Divide total by number of participants):	25961.26
Average Length of Stay on the Waiver:	356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	One-way trip	0	0.00	5.79		
	GRAND TOTAL:					5841283.37
	Total Estimated Unduplicated Participants:					225
	Factor D (Divide total by number of participants):					25961.26
	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:						0.00
Adult Day Health Care	15 minutes	0	0.00	2.78	0.00	
Day Habilitation Total:						253598.00
Day Habilitation	2.5 hours	46	298.00	18.50	253598.00	
Prevocational Services Total:						182677.50
Prevocational Services	2.5 hours	23	353.00	22.50	182677.50	
Respite Services - Out of Home Total:						1111.68
Respite Services - Out of Home	15 minutes	12	24.00	3.86	1111.68	
Shared Living Services Total:						3247335.00
Shared Living Services	Per Diem	182	305.00	58.50	3247335.00	
Support Coordination Total:						622635.00
Support Coordination	15 minutes	325	103.00	18.60	622635.00	
Supported Employment Total:						16536.00
Supported Employment	15 minutes	30	212.00	2.60	16536.00	
Assistive Technology/Specialized Medical Equipment and Supplies Total:						2772.00
Assistive Technology/Specialized Medical Equipment and Supplies	Per Item	12	1.00	231.00	2772.00	
Dental Total:						2119.32
Dental	Per Procedure	12	3.00	58.87	2119.32	
Community Living Supports Total:						3494430.98
Community Living Supports					3494430.98	
GRAND TOTAL:						8634435.98
Total Estimated Unduplicated Participants:						325
Factor D (Divide total by number of participants):						26567.50
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	53	17081.00	3.86		
Companion Care Total:						179580.00
Companion Care	Per Diem	12	365.00	41.00	179580.00	
Environmental Accessibility Adaptations Total:						149257.80
Environmental Accessibility Adaptations	Per Item	12	3.00	4146.05	149257.80	
Host Home Total:						4725.70
Host Home	Per Diem	86	1.00	54.95	4725.70	
Housing Stabilization Service Total:						2175.84
Housing Stabilization Service	15 minutes	2	72.00	15.11	2175.84	
Housing Stabilization Transition Service Total:						2810.46
Housing Stabilization Transition Service	15 minutes	2	93.00	15.11	2810.46	
Nursing Total:						408209.10
Nursing	15 minutes	30	1703.00	7.99	408209.10	
One-Time Transitional Services Total:						36000.00
One-Time Transitional Services	Per Package	12	1.00	3000.00	36000.00	
Personal Emergency Response System Total:						4053.60
Personal Emergency Response System	Monthly	12	12.00	28.15	4053.60	
Professional Services Total:						24408.00
Licensed Clinical Social Work	15 minutes	12	24.00	7.50	2160.00	
Registered Dietician	15 minutes	12	24.00	9.00	2592.00	
Occupational Therapy	15 minutes	12	24.00	12.00	3456.00	
Speech Therapy	15 minutes	12	24.00	11.25	3240.00	
Psychology	15 minutes	12	24.00	31.25	9000.00	
Physical Therapy	15 minutes	12	24.00	13.75	3960.00	
Transportation - Community Access Total:						0.00
Transportation - Community Access	One-way trip	0	0.00	5.79	0.00	
	GRAND TOTAL:					8634435.98
	Total Estimated Unduplicated Participants:					325
	Factor D (Divide total by number of participants):					26567.50
	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:						1003046.24
Adult Day Health Care	15 minutes	68	5306.00	2.78	1003046.24	
Day Habilitation Total:						187442.00
Day Habilitation	2.5 hours	34	298.00	18.50	187442.00	
Prevocational Services Total:						135022.50
Prevocational Services	2.5 hours	17	353.00	22.50	135022.50	
Respite Services - Out of Home Total:						370.56
Respite Services - Out of Home	15 minutes	4	24.00	3.86	370.56	
Shared Living Services Total:						374692.50
Shared Living Services	Per Diem	21	305.00	58.50	374692.50	
Support Coordination Total:						498108.00
Support Coordination	15 minutes	325	103.00	14.88	498108.00	
Supported Employment Total:						9370.40
Supported Employment	15 minutes	17	212.00	2.60	9370.40	
Assistive Technology/Specialized Medical Equipment and Supplies Total:						3003.00
Assistive Technology/Specialized Medical Equipment and Supplies	Per Item	13	1.00	231.00	3003.00	
Dental Total:						2119.32
Dental	Per Procedure	12	3.00	58.87	2119.32	
Community Living Supports Total:						8152538.81
Community Living Supports	15 minutes	247	9143.00	3.61	8152538.81	
Companion Care Total:						134685.00
Companion Care	Per Diem	9	365.00	41.00	134685.00	
Environmental Accessibility Adaptations Total:						49752.60
Environmental Accessibility Adaptations	Per Item	4	3.00	4146.05	49752.60	
Host Home Total:						4231.15
Host Home	Per Item	77	1.00	54.95	4231.15	
Housing Stabilization Service Total:						1087.92
				GRAND TOTAL:		10787631.56
				Total Estimated Unduplicated Participants:		325
				Factor D (Divide total by number of participants):		33192.71
				Average Length of Stay on the Waiver:		356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Housing Stabilization Service	15 minutes	1	72.00	15.11	1087.92	
Housing Stabilization Transition Service Total:						1405.23
Housing Stabilization Transition Service	15 minutes	1	93.00	15.11	1405.23	
Nursing Total:						176890.61
Nursing	15 Minutes	13	1703.00	7.99	176890.61	
One-Time Transitional Services Total:						30000.00
One-Time Transitional Services	Per Package	10	1.00	3000.00	30000.00	
Personal Emergency Response System Total:						14525.40
Personal Emergency Response System	Monthly	43	12.00	28.15	14525.40	
Professional Services Total:						8136.00
Licensed Clinical Social Work	15 minutes	4	24.00	7.50	720.00	
Registered Dietician	15 minutes	4	24.00	9.00	864.00	
Occupational Therapy	15 minutes	4	24.00	12.00	1152.00	
Speech Therapy	15 minutes	4	24.00	11.25	1080.00	
Psychology	15 minutes	4	24.00	31.25	3000.00	
Physical Therapy	15 minutes	4	24.00	13.75	1320.00	
Transportation - Community Access Total:						1204.32
Transportation - Community Access	One-way trip	4	52.00	5.79	1204.32	
				GRAND TOTAL:		10787631.56
				Total Estimated Unduplicated Participants:		325
				Factor D (Divide total by number of participants):		33192.71
				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:						1003046.24
Adult Day Health Care					1003046.24	
				GRAND TOTAL:		11157497.38
				Total Estimated Unduplicated Participants:		325
				Factor D (Divide total by number of participants):		34330.76
				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	68	5306.00	2.78		
Day Habilitation Total:						187442.00
Day Habilitation	2 5 hours	34	298.00	18.50	187442.00	
Prevocational Services Total:						135022.50
Prevocational Services	2 5 hours	17	353.00	22.50	135022.50	
Respite Services - Out of Home Total:						370.56
Respite Services - Out of Home	15 minutes	4	24.00	3.86	370.56	
Shared Living Services Total:						374692.50
Shared Living Services	Per Diem	21	305.00	58.50	374692.50	
Support Coordination Total:						498108.00
Support Coordination	15 minutes	325	103.00	14.88	498108.00	
Supported Employment Total:						9370.40
Supported Employment	15 minutes	17	212.00	2.60	9370.40	
Assistive Technology/Specialized Medical Equipment and Supplies Total:						3003.00
Assistive Technology/Specialized Medical Equipment and Supplies	Per Item	13	1.00	231.00	3003.00	
Dental Total:						3355.59
Dental	Per Procedure	19	3.00	58.87	3355.59	
Community Living Supports Total:						8416588.65
Community Living Supports	15 minutes	255	9143.00	3.61	8416588.65	
Companion Care Total:						134685.00
Companion Care	Per Diem	9	365.00	41.00	134685.00	
Environmental Accessibility Adaptations Total:						74628.90
Environmental Accessibility Adaptations	Per Item	6	3.00	4146.05	74628.90	
Host Home Total:						4231.15
Host Home	Per Diem	77	1.00	54.95	4231.15	
Housing Stabilization Service Total:						1087.92
Housing Stabilization Service	15 minutes	1	72.00	15.11	1087.92	
Housing Stabilization Transition Service Total:						1405.23
Housing Stabilization Transition Service	15 minutes	1	93.00	15.11	1405.23	
Nursing Total:						244925.46
			GRAND TOTAL:			11157497.38
			Total Estimated Unduplicated Participants:			325
			Factor D (Divide total by number of participants):			34330.76
			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	18	1703.00	7.99	244925.46	
One-Time Transitional Services Total:						30000.00
One-Time Transitional Services	Per Package	10	1.00	3000.00	30000.00	
Personal Emergency Response System Total:						14525.40
Personal Emergency Response System	Monthly	43	12.00	28.15	14525.40	
Professional Services Total:						10170.00
Licensed Clinical Social Work	15 minutes	5	24.00	7.50	900.00	
Registered Dietician	15 minutes	5	24.00	9.00	1080.00	
Occupational Therapy	15 minutes	5	24.00	12.00	1440.00	
Speech Therapy	15 minutes	5	24.00	11.25	1350.00	
Psychology	15 minutes	5	24.00	31.25	3750.00	
Physical Therapy	15 minutes	5	24.00	13.75	1650.00	
Transportation - Community Access Total:						10838.88
Transportation - Community Access	One-way trip	36	52.00	5.79	10838.88	
	GRAND TOTAL:					11157497.38
	Total Estimated Unduplicated Participants:					325
	Factor D (Divide total by number of participants):					34330.76
	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:						1091550.32
Adult Day Health Care	15 minutes	74	5306.00	2.78	1091550.32	
Day Habilitation Total:						198468.00
Day Habilitation	2.5 hours	36	298.00	18.50	198468.00	
Prevocational Services Total:						142965.00
Prevocational Services	2.5 hours	18	353.00	22.50	142965.00	
	GRAND TOTAL:					12545269.94
	Total Estimated Unduplicated Participants:					350
	Factor D (Divide total by number of participants):					35843.63
	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 Total:						463.20
Respite Services - Out of Home	15 minutes	5	24.00	3.86	463.20	
Shared Living Services Total:						410377.50
Shared Living Services	Per Diem	23	305.00	58.50	410377.50	
Support Coordination Total:						536424.00
Support Coordination	15 minutes	350	103.00	14.88	536424.00	
Supported Employment Total:						9921.60
Supported Employment	15 minutes	18	212.00	2.60	9921.60	
Assistive Technology/Specialized Medical Equipment and Supplies Total:						3234.00
Assistive Technology/Specialized Medical Equipment and Supplies	Per Item	14	1.00	231.00	3234.00	
Dental Total:						4238.64
Dental	Per Procedure	24	3.00	58.87	4238.64	
Community Living Supports Total:						9439781.78
Community Living Supports	15 minutes	286	9143.00	3.61	9439781.78	
Companion Care Total:						149650.00
Companion Care	Per Diem	10	365.00	41.00	149650.00	
Environmental Accessibility Adaptations Total:						136819.65
Environmental Accessibility Adaptations	Per Item	11	3.00	4146.05	136819.65	
Host Home Total:						4560.85
Host Home	Per Diem	83	1.00	54.95	4560.85	
Housing Stabilization Service Total:						1087.92
Housing Stabilization Service	15 minutes	1	72.00	15.11	1087.92	
Housing Stabilization Transition Service Total:						1405.23
Housing Stabilization Transition Service	15 minutes	1	93.00	15.11	1405.23	
Nursing Total:						340174.25
Nursing	15 minutes	25	1703.00	7.99	340174.25	
One-Time Transitional Services Total:						30000.00
One-Time Transitional Services	Per Package	10	1.00	3000.00	30000.00	
Personal Emergency Response System Total:						16890.00
Personal Emergency Response System	Monthly	50	12.00	28.15	16890.00	
	GRAND TOTAL:					12545269.94
	Total Estimated Unduplicated Participants:					350
	Factor D (Divide total by number of participants):					35843.63
	Average Length of Stay on the Waiver:					356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Professional Services Total:						**12204.00**
Licensed Clinical Social Work	15 minutes	6	24.00	7.50	**1080.00**	
Registered Dietician	15 minutes	6	24.00	9.00	**1296.00**	
Occupational Therapy	15 minutes	6	24.00	12.00	**1728.00**	
Speech Therapy	15 minutes	6	24.00	11.25	**1620.00**	
Psychology	15 minutes	6	24.00	31.25	**4500.00**	
Physical Therapy	15 minutes	6	24.00	13.75	**1980.00**	
Transportation - Community Access Total:						**15054.00**
Transportation - Community Access	One-way trip	50	52.00	5.79	**15054.00**	
				GRAND TOTAL:		**12545269.94**
				Total Estimated Unduplicated Participants:		**350**
				Factor D (Divide total by number of participants):		**35843.63**
				Average Length of Stay on the Waiver:		356