Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

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

a. PLAN OF CARE DEVELOPMENT AND TIMING

- Initial Support Coordinator (SC) contact, with the participant, occurs within three (3) business days of being linked to the agency of choice.
- Plan of Care (POC) development must begin within seven (7) calendar days of linkage to the SC agency of choice.
- The SC contacts the participant to arrange a planning meeting at a time and location convenient to the participant.
- The POC is developed through a collaborative support team process involving the participant, family, friends or other support systems, legal representatives, the SC, appropriate professionals/service providers, and others who the participant chooses to be involved.
- The POC must be completed and received in the LGE within 35 calendar days following linkage.
- The LGE staff have ten (10) working days in which to review the information, complete the precertification home visit and approve the POC prior to waiver services beginning.
- Every 12 months, the SC and the participant, and others the participant chooses to be present, review the POC to determine if the goals identified on the POC are being achieved, the participant's needs, including health and welfare are being addressed, and to make any adjustments or changes to the POC as necessary.
- The entire team meets annually to review and revise the POC for the upcoming service year. The annual date of the POC does not change, even if there has been a recent meeting to revise the services.

b. ASSESSMENTS

- Personal interviews are conducted with each participant during the POC development process.
- The initial assessment must begin within seven (7) calendar days of the referral/linkage and be completed within 30 calendar days of the referral/linkage.
- During the assessment process the SC collects the following information:
  i. The personal outcomes envisioned, defined and prioritized by the participant;
  ii. Medical/physical information and documentation; psychosocial/behavioral information and documentation such as, school evaluations, DD SNAP, ICAP and all available documentation.
  iii. Developmental/intellectual information and documentation;
  iv. Socialization/recreational information and documentation, including relationships that are important to the participant and the social environment of the participant;
  v. Patterns of the participant's everyday life;
  vi. Identification of natural supports;
  vii. Information and documentation on financial resources;
  viii. Educational/vocational information and documentation;
  ix. Information on the current status of housing and the physical environment;
  x. Information about previously successful and unsuccessful strategies to achieve the participant's desired personal outcomes; and
  xi. Any other information relevant to understanding the supports and services needed by the participant to achieve the desired personal outcomes.
- A reassessment may be conducted at any time, particularly with a significant change, but must be completed within seven (7) calendar days of notice of a change in the participant's status. The assessment process is ongoing, and designed to reflect changes in the participant's life, individual needs, and changing personal outcomes, including strengths, needs, preferences, abilities, and resources.

c. HOW PARTICIPANTS ARE INFORMED OF AVAILABLE SERVICES

- The participant and his/her legal representatives are informed of available waiver services during the initial contact with the SC and again during the POC development process.

d. INCORPORTATION OF PARTICIPANT GOALS/NEEDS/PREFERENCES IN PLAN

• The POC must incorporate the following required components:
i. The participant's needs, preferences, prioritized personal outcomes and specific strategies to achieve or maintain the desired personal outcomes, focusing first on natural/community supports and, if needed, paid services;
ii. An action plan which will lead to the implementation of strategies to address the participant's needs and achieve his/her desired personal outcomes, including action steps, review dates and individuals who will be responsible for specific steps, ensuring that the steps which are incorporated empower and help the participant to develop independence, growth, and self-management;
iii. Budget payment mechanism, as applicable;
iv. Target/resolution dates for the achievement/maintenance of personal outcomes;
v. Frequency and location of the SC's face-to-face contacts with the participant, service providers, and others in the support network;
vi. Identification of the preferred formal and informal service providers and specification of the service arrangements; and
vii. Identification of individuals who will assist the SC in planning, building/implementing supports, or direct services; and
viii. Signatures on the POC from the participant and all support team members present indicating their agreement with the POC.
• It is the requirement of this information and its inclusion in the POC that ensures the participant's goals, needs, including health care needs, and preferences are addressed.
e. COORDINATION OF WAIVER SERVICES
• Waiver and other identified services on the POC are coordinated through the SC.
• SC's are required to make monthly contact with each participant, and make a quarterly face-to-face visit in the participant's place of residence and/or place of employment/vocational training location. During these contacts SC's review information on the POC, track progress on identified goals and timelines, and get updated information on the progress of natural supports identified on the POC.
• The participant and his/her legal representatives may contact the SC at any time for assistance. Formal monthly contacts offer another opportunity for the participant and his/her legal representatives to request a support team meeting in order to make formal revisions to the POC, and for the SC to request to do a reassessment or provide for a new evaluation.
f. ASSIGNMENT OF RESPONSIBILITIES TO IMPLEMENT AND MONITOR PLAN
• Each goal identified on the POC has a time frame for accomplishment. The SC is responsible for monitoring the progress of goals to ensure that they are completed or revisions are made as necessary when identified goals change, or cannot be accomplished within the identified time frames.
• During the development of the POC different support team members volunteer, or are asked to take on roles and responsibilities to facilitate linkage of the participant to the identified services and supports that are outside of the paid Medicaid services. The SC gets information on the progress of these assignments during monthly contacts with the participant and his/her legal representatives.
g. HOW AND WHEN PLAN IS UPDATED
• The POC is revised annually or as necessary to meet the needs of the participant and submitted to the appropriate LGE no later than thirty –five (35) calendar days prior to expiration.
• SC will approve the annual POC's of participants whose health and welfare can be assured with current amounts of waiver services, POC's that have no changes in services and are meeting the service needs of the participant. All plans must be submitted to LGEs.
• The SC contacts the participant to arrange a POC meeting at a time and location convenient to the participant.
• Changes must be reflected in a POC revision submitted to the appropriate LGE.
• Emergency POC revisions must be submitted within twenty-four hours (24), or the next working day of the occurrence.
• Routine POC revisions, such as vacations or family schedules, must be submitted seven (7) working days prior to the change.
• The participant may request a complete POC review by the LGE staff at any time during POC year if they believe current POC to be unsatisfactory or is inadequate in meeting their service needs.

Appendix D: Participant-Centered Planning and Service Delivery

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

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant

needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

••Information from various assessments conducted during the planning process is used to identify any potential risks, which are then addressed through mitigation strategies that are included in the POC.
•In addition, information gained during interviews with the participant and his/her legal representatives and support team members, as well as information from the LGE pre-certification visit is also used during the initial planning process to identify potential risks to the participant.
•The participant and all support team members are given informed choice regarding the inclusion of any strategies recommended to be included in an initial or revised POC. The initial or revised POC with the included strategies must be signed and dated by all support team members.
•Recommendations from support team members on strategies to mitigate specific risk are incorporated into the POC. LGE reviews recommendations, makes additional recommendations, and/or refers the issue to the OCDD State Office for input prior to approval of an initial or revised POC.

BACK-UP PLANS
• All enrolled providers of waiver services must possess the capacity to provide the support and services required by the participant in order to insure the participant's health and welfare as outlined in the POC, and are required to have functional Individualized Back-Up Plans consistent with the participant's POC. When paid supports are scheduled to be provided by an enrolled provider of waiver services, that provider is responsible for providing all necessary staff to fulfill the health and welfare needs of the participant, including times when scheduled direct support staff is absent, unavailable or unable to work for any reason.
•The identified enrolled provider of waiver services cannot use the participant's informal support system as a means of meeting the agency's individualized back-up plan, and/or emergency evacuation response plan requirements unless agreed to by the participant/family because the family prefers to make other arrangements.
• The identified enrolled provider of waiver services must have in place policies and procedures that outline the protocols the agency has established to assure that back-up direct support staff are readily available, lines of communication and chain-of-command have been established, and procedures are in place for dissemination of the back-up plan information to participants, their legal representatives, and SC.
• It is the identified enrolled provider of waiver services' responsibility to develop the back-up plan and provide it to the SC in a time frame that will allow it to be submitted for review/approval as a part of the POC.
• The SC is responsible for working with the participant, his/her family, friends, and providers during initial and subsequent POC meetings to establish plans to address these situations.
• The SC assists the participant and the support team members to identify individuals who are willing and able to provide a back-up system during times when paid supports are not scheduled on the participant's POC.
• All back-up plans must include detailed strategies and person-specific information that addresses the specialized care and supports needed by the participant as identified in the POC. Back-up POC must be updated no less than annually to assure information is kept current and applicable to the participant's needs at all times.

EMERGENCY EVACUATION PLANS
• An Emergency Evacuation Response Plan must be developed in addition to the individual back-up POC, be included in the participant's POC, and reviewed a minimum of once each POC year.
• An Emergency Evacuation Response Plan provides detailed information for responding to potential emergency situations such as fires, hurricanes, hazardous materials release, tropical storms, flash flooding, ice storms, and terrorist acts.
• The Emergency Evacuation Response Plan must include at a minimum the following components:
  • Individualized risk assessment of potential health emergencies;
  • Geographical and natural disaster emergencies, as well as potential for any other emergency conditions;
  • A detailed plan to address participant's individualized evacuation needs, including a review of individualized backup POC;
  • Policies and procedures outlining the agency's protocols regarding implementation of Emergency Evacuation Response Plans and how these plans are coordinated with the local Office of Emergency Preparedness and Homeland Security;
  • Establishment of effective lines of communication and chain-of-command, and procedures for dissemination of Emergency Response Plan to participants and SCs;
  • Protocols outlining how and when direct support staff and participants are to be trained in Emergency Evacuation Response Plan implementation and post emergency protocols;
• Training for direct support staff must occur prior to any worker being solely responsible for the support of the

participant, and participants must be provided with regular, planned opportunities to practice the Emergency Evacuation Response Plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

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

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

Part of this contact involves a discussion of Freedom of Choice of enrolled waiver providers, the availability of all services, as well as what the participant and his/her legal representatives require from SC. The Freedom of Choice list includes all providers in the participant's region that are enrolled to provide specific waiver services.

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

The SC can assist the participant in setting up appointments to interview the different provider agencies, they can assist the participant regarding what questions they can ask the potential providers, and they can refer them to Families Helping Families or other advocacy groups. The SC will assist with any other needs the participant may have in selecting a qualified provider.

The SC is not allowed to make recommendations and does not coerce the participant in making their decision.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

•Through a Memorandum of Understanding (MOUs) with OCDD and Human Services Authorities/Districts (HSA/D) now referred to as the Local Governing Entity (LGE), the Medicaid agency (BHSF) has delegated approval of the POC. BHSF will receive data reports quarterly and/or conduct reviews of documents (which may include plans of care) as part of the BHSF's oversight activities. This is done to assure that the operating agency is complying with all HCBS regulations related to service planning, is following the Supports Waiver application requirements, and is identifying areas of deficiency on the POC and implementing appropriate corrective actions. OCDD and/or LGE and BHSF will collaborate on any corrective actions as needed.

The LGE through delegation contained in the MOU, reviews and approves 100% of all initial Plans of Care and revisions to Plans of Care. Annual Plans of Care may be approved by SCs or LGE based on OCDD Policy and Procedures. LGE staff will review the annual POC during SC monitoring. LGE staff conducts these reviews to assure the following:

•That all supports and services needed by the participant to achieve his goals, regardless of funding source or availability are identified on the POC;
•Information from any standardized assessments is included;
•Information in the POC is compatible with the LOC;
•Potential risks are identified and strategies are included to mitigate risks; and
•Personal outcomes are identified and the POC includes actions to achieve/maintain priority personal goals of the participant.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

- **Every three months or more frequently when necessary**
- **Every six months or more frequently when necessary**
- (●) **Every twelve months or more frequently when necessary**
- **Other schedule**

Specify the other schedule:

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

- [ ] **Medicaid agency**
- [x] **Operating agency**
- [x] **Case manager**
- [ ] **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

•The SC is responsible for monitoring the implementation of the POC, the participant's health and welfare and the effectiveness of the POC in meeting the participant's needs and preferences.

The SC contacts the participant within ten (10) working days after the initial POC is approved to assure the appropriateness and adequacy of service delivery.

SC makes monthly contacts with each participant. One contact per quarter must be a face-to-face visit in the participant's place of residence, place of employment and/or vocational service option location.

During these contacts the SC checks to make sure that:

- There is access to waiver and non-waiver services identified in the POC, including access to health services;
- The services outlined on the POC meet the needs of the participant;
- The participant is satisfied with the service providers he/she has chosen;
- Services are being furnished in accordance with the POC;
- The participant's health and welfare needs are being met; and
- Back-up Plan, if utilized, is effective.

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

Revisions to the POC reflect the results of the monitoring. During the monitoring of POC implementation, if changes are needed a revision to the POC will be completed. All revisions must be reviewed and prior approved by

LGE. Emergency revisions to the POC must be submitted to the LGE within 24 hours or next business day. Routine revisions must be submitted to the LGE within seven (7) days prior to the change.

b. Monitoring Safeguards. *Select one:*

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

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.a.i.a.2. Number and percentage of participants whose plan of care has strategies that address their health and safety risks as indicated in the assessment. Numerator = Number of participants whose plan of care has strategies that address their health and safety risks as indicated in the assessment; Denominator = total number of plans of care reviewed in the sample.

Data Source (Select one):
Other

If 'Other' is selected, specify:
LOC/POC database

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

Data Aggregation and Analysis:

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

Performance Measure:
D.a.i.a.3. Number and percentage of plans of care that address participants' personal goals. Numerator = Number of plans of care that address participants' personal goals; Denominator = total number of plans of care reviewed in the sample.

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

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

Data Aggregation and Analysis:

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

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:

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

Performance Measures

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

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

Performance Measure:
D.a.i.b.1. Number and percentage of plans of care that were developed in required timelines in accordance with policies and procedures. Numerator = Number of plans of care that were developed in required timelines in accordance with policies and procedures; Denominator = Total number of plans of care reviewed in the sample.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
D.a.i.c.1. Number and percentage of participants whose plans of care were updated/revised on or before the participant's annual review date. Numerator = Number of plans of care that were updated/revised on or before the participant's

annual review date; Denominator = Total number of plans of care that were reviewed in the sample.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
D.a.i.c.2. Number and percentage of participants whose plans of care were reviewed and revised as needed to address the participants changing needs. Numerator =number of participants whose plans of care were reviewed and revised as needed to address the participants changing needs; Denominator = Total number of plans of care reviewed in the sample.

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
D.a.i.d.1. Number and percentage of participants who receive services in the amount, frequency and duration specified in their plan of care. Numerator = Number of participants who received services in the amount, frequency and duration specified in their plan of care; Denominator = Total number of participants reviewed in the sample.

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

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

		☑ **Representative Sample** Confidence Interval = 95%+/- 5%
☑ **Other** Specify: Medicaid Data Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information

on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.a.i.e.1 Number and percentage of initial applicants who received a choice between waiver and institutional services as documented by an appropriately completed freedom of choice form. Numerator = Number of initial applicants who received choice between waiver and institutional services; Denominator = Total number of initial applicants in the sample.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
D.a.i.e.2. Number and percentage of waiver participants who received a choice of available waiver service providers, as documented by a signed plan of care. Numerator = Number of participants who received a choice of waiver service providers as documents by a signed plan of care; Denominator = Total plans of care reviewed in the sample.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
D.a.i.e.3. Number and percentage of participants with a signed plan of care which verifies that the participant received a choice of available services. Numerator = number of participants with a signed plan of care which verifies that the participant received a choice of available services; Denominator = Total number of plans of care reviewed in the sample.

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

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

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

Data Aggregation and Analysis:

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

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.
Performance Measures D.a.i.a.1, D.a.i.a.2, D.a.i.a.3, D.a.i.b.1, D.a.i.c.1, D.a.i.c.2 D.a.i.e.1, D.a.i.e.2 and D.a.i.e.3: As indicated by a review of the LOC/POC data, LGE's offices will be required by OCDD State Office to submit a corrective action plan to remediate any identified issues as related to the applicants/participants plan of care as well as action to minimize the likelihood of similar problems from reoccurring (e.g., staff training, supervisory monitoring, etc.).

The request for remediation will be entered into a database with the date of the request for a corrective action plan and the issue(s) to be addressed. The LGE's /Support Coordination Agency will have up to 10 calendar

days to submit a corrective action plan for approval to the OCDD State Office. The OCDD State Office will have 5 working days to review and approve or disapprove the corrective action plan. If the corrective action plan is not approved, a revised corrective action plan from the LGE/Support Coordination Agency will be due within 5 calendar days. Throughout this process OCDD State Office will provide technical assistance to the LGE/ Support Coordination Agency, as needed. The dates that the corrective action plan and revised plan, if applicable, were received, reviewed, and approved or not approved, as well as a description of the corrective action to be taken, will be entered into the database. OCDD State Office will follow-up with the LGE's to assure that the corrective actions were implemented as per the corrective action plan and entered into the database.

Data, such as the number of applicants/participants for whom specific types of remediation were required and the timeliness of corrective action, will be aggregated to identify trends and patterns.

During the Level of Care/Plan of Care (LOC/POC) Quality Review:
- Items needing remediation are flagged by the data system;
- Specific information related to the flagged item is entered into the data system;
- Remediation is tracked by verification of actions taken; and
- Once remediation is completed, the case is closed.

On a quarterly basis at the State Office level, remediation data is aggregated and reviewed by the Performance Review Committee to assure that all cases needing remediation are addressed. Trends and patterns are identified in order to improve performance.

Performance Measures: D.a.i.d.1: The OCDD Waiver Program Manager receives quarterly reports from the Medicaid Data Contractor in order to review trends and patterns of under-utilization of services. If the OCDD Waiver Program Manager discovers under-utilization of certain services or lack of availability of services, etc., due to a particular agency,the OCDD Waiver Program Manager will bring the issue to OCDD Waiver Supports and Services Executive Director for review and resolution. Referrals may be made to the OCDD Performance Review committee for recommendation for further remediation.

The remediation activities for this measure will be documented in electronic format by the OCDD Waiver Program Manager.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

Yes

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

Appendix E: Participant Direction of Services

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

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

Yes. The State requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

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

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

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

During the initial assessment process, which must begin within seven (7) calendar days of referral/linkage of the participant to the support coordination agency, the support coordinator will give a participant and his/her legal representatives an OCDD information sheet entitled "Rights and Responsibilities for Applicants/Participants of a Home and Community Based Waiver" which includes information on how to file a complaint, grievance, or appeal with the Louisiana Department of Health and Hospitals. A copy of this information sheet is kept in the participant's record at the support coordination

agency's physical location of business. In addition, the plan of care contains a section that addresses the right to a fair hearing within ten (10) days, and how to request a fair hearing, if the participant and his/her legal representatives disagree with any decision rendered regarding approval of the plan. Dated signatures of the participant, his/her legal representatives, and a witness are required on this section. Copies of the plan of care, including this section are kept in the appropriate Local Governing Entity (LGE) and the support coordination agency's physical location of business.

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

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

In accordance with 42CFR 431.206, 210 and 211, participants receiving waiver services, and their legal representatives are sent a certified letter with return receipt to ensure the participant receives it by the appropriate LGE providing ten (10) days advance and adequate notification of any proposed denial, reduction, or termination of waiver services. Included in the letter are instructions for requesting a fair hearing, and notification that an oral or written request must be made within ten (10) days of receipt of a proposed adverse action by the LGE in order for current waiver services to remain in place during the appeal process. If the appeal request is not made within ten (10) days, but is made within thirty (30) days, all Medicaid waiver services are discontinued on the eleventh (11) day; services that are continued until the final decision is rendered are not billable under the Medicaid waiver. If the final decision of the Administrative Law Judge is favorable to the appellant, services are re-implemented from the date of the final decision. An appeal hearing is not granted if the appeal request is made later than thirty (30) days following receipt of a proposed adverse action sent by the LGE. Once a request for an appeal is received, the LGE must submit the request to the Division of Administrative Law no later than seven (7) calendar days after receipt. A copy of the letter and the response/request is kept in the participant's record at the appropriate LGE.

During an appeal request and/or fair hearing the Support Coordinator provides:

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

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

Enrolled providers of waiver services provide participants and their legal representative notice in writing at least fifteen (15) days prior to the transfer or discharge from the provider agency with the proposed date of the transfer/discharge, the reason for the action, and the names of personnel available to assist the participant throughout the process. The enrolled provider of waiver services must also provide the participant and his/her legal representative with information on how to request an appeal of a decision for involuntary discharge. A copy of the notice of intent to transfer/discharge, and information that was provided on how to access the appeal process is kept in the participant's record at the enrolled provider of waiver services physical location of business.

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

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- ◉ **No. This Appendix does not apply**
- ○ **Yes. The State operates an additional dispute resolution process**

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

The Department of Health and Hospital, Health Standards Section (HSS) is responsible for the operation of the grievance/complaint system that involves licensing.

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

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

•The OCDD and/or LGE is responsible for receiving, reporting and responding to customer complaints received from individuals supported through their office including those supported through the waiver. A complaint is a written or verbal statement expressing concern or dissatisfaction, which calls for action/resolution. Each OCDD entity including LGE and State Office are responsible for receiving, reporting, and responding to customer complaints. Each OCDD entity is responsible for training their staff, participants, their families, and providers regarding OCDD's policy on customer complaints. A complaint may be made in person or by phone, fax, e-mail or mail to an OCDD entity. When a complaint is received by OCDD and/or LGE the complaint is triaged to determine if the complaint can be resolved by OCDD or if the complaint needs to be referred to another agency (Health Standards Section, Program Integrity, Protective Services etc.) for action/resolution. The initiation of the complaint review and follow-up occurs within two (2) business days of receipt of the complaint. Actions to resolve the complaint will be completed within thirty (30) calendar days of receipt of the complaint. A written response describing the actions in response to the complaint is mailed to the complainant within five (5) business days of the complaint action/resolution. OCDD and/or LGE will continue to follow up with other agencies regarding complaint action/resolution. All complaints are entered into a data base for tracking of complaints and quality management purposes.

The Department of Health and Hospitals, Health Standards Section (HSS) is responsible for the operation of the Home and Community Based Waiver Complaint Line regarding complaints against licensed providers.

• The HSS complaint line is the central point of entry for all complaints regarding the waiver. The HSS maintains

an established complaint line with a toll free number for participants and their legal representatives.
• The nature and scope of the complaint is at the discretion of the individual registering the complaint.
• The complaint line number is printed on business cards, brochures, and fact sheets. It is given to participants and their legal representative(s) at intake by their support coordinator. During the pre-certification visit the LGE staff checks to make sure that the information has been given to them. The support coordinator reviews the information during quarterly face to face visits, and each year at the annual plan of care team meeting, or whenever it is requested by the participant and his/her legal representative(s).

HSS and LGE staff, as well as, support agencies (e.g. Families Helping Families), distribute the HSS complaint line information when assisting participants and their legal representative(s). Direct service providers are also required to give the complaint line number to all participants.
• Support coordinators are responsible for informing participants and their legal representative(s) initially, annually or whenever information about the system is requested that filing a grievance or complaint is not a pre-requisite or substitute for a Fair Hearing. LGE staff checks to make sure that this information has been relayed to them during the pre-certification visit.
• If the LGE or OCDD State Office staff is contacted by a participant/legal representative(s), other state agency, support coordinator or provider wishing to file a complaint, the LGE or OCDD State Office staff will refer the complaint by fax to the HSS complaint line within 24 hours for tracking and distribution.
• HSS triages all complaints in the following manner:
•Provider non-compliance licensing issues are resolved by HSS.
•Complaints identified as abuse, neglect, exploitation or extortion are referred immediately to the appropriate bureau of protective services (Child Protective Services, Adult Protective Services).
•All other types of complaints are referred to OCDD State Office for incident resolution. Complaints identified as critical events or incidents are investigated by the appropriate office within thirty (30) days of receipt of such report.

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*

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

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

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

•Abuse (adult), as defined in Louisiana Revised Statute15:503.
•Exploitation (adult), as defined in Louisiana Revised Statute15:503.

•Extortion (adult), as defined in Louisiana Revised Statute 15:503.
•Neglect (adult), as defined in Louisiana Revised Statute 15:503.
•Death, as defined in OCDD Critical Incident Report Operational Instruction F-5.
•Fall, as defined in OCDD Critical Incident Report Operational Instruction F-5.
•Involvement with Law Enforcement, as defined in OCDD Critical Incident Report Operational Instruction F-5.
•Loss or Destruction of Home, as defined in OCDD Critical Incident Report Operational Instruction F-5.
•Major Behavioral Incident, as defined in OCDD Critical Incident Report Operational Instruction F-5.
•Major Illness, as defined in OCDD Critical Incident Report Operational Instruction F-5.
•Major Injury, as defined in OCDD Critical Incident Report Operational Instruction F-5.
•Missing, as defined in OCDD Critical Incident Report Operational Instruction F-5.
•Restraint Use, as defined in OCDD Critical Incident Report Operational Instruction F-5.

Louisiana Revised Statute 14:403.2 defines reporting criteria pertaining to reporting requirements for any known or suspected abuse, neglect, exploitation or extortion .

The Direct Service Provider (DSP) staff must notify the support coordination agency of all critical incidents immediately upon discovery or within 2 hours of the incident after taking all necessary actions to protect the participant from further harm and responding to the emergency needs of the participant. The DSP must forward a written Critical Incident Report to the Support Coordinator/ Agency within 24 hours of the incident discovery. The support coordinator enters the critical incident information into the Online Tracking System (OTIS) by close of the next business day.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

A Rights and Responsibilities form and a HIPAA form are completed during the initial Single Point of Entry Determination Process for System Entry intake interview with the individual and his/her legal representatives.

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

• During the Pre-Certification Visit (after the assessment process and plan of care have been completed, but prior to services being initiated) the Local Governing Entity (LGE) staff will review all information, including information about abuse and neglect, with the participant and his/her legal representative,; make sure that they have phone numbers for the HSS complaint line, the LGE office number, and the support coordination agency number for reporting purposes; and that they understand their rights and responsibilities and have been given a copy of the OCDD Rights and Responsibilities for Applicants/Recipients of a Home and Community Based Waiver.

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

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Reports/Evaluation of Reports/Investigations/Timeframes:

• Direct Support Provider:
o The provider must review each critical incident and assure that the participant is protected from further harm and respond to any emergency needs of the participant.
o If abuse/neglect/exploitation/extortion is suspected, provider must immediately contact the appropriate protective service agency. The provider must cooperate with the appropriate protective service agency once the

agency has been notified and an investigation commences. The provider is required to provide relevant information, records, and access to members of the agency conducting the investigation.

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

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

• Support Coordinator:

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

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

o Convene planning meetings that may be required to resolve the critical incident or to develop strategies to prevent or mitigate the likelihood of similar critical incidents from occurring in the future.

o Obtain the participant summary from the web-based Online Tracking System (OTIS) after closure by the LGE and forward to the provider and participant within 15 days.

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

• LGE:

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

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

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

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

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

o Make timely referrals to other agencies as necessary.

o Staff will complete the participant summary and assure closure of the Critical Incident within timelines set in policy (OCDD Critical Incident Report Operational Instruction F-5).

• APS(ages 18 and above):

o Upon receipt of an allegation or report of abuse, neglect, exploitation, or extortion involving an adult/elderly participant by a family member or legal guardian, APS investigates based upon their internal policy and guidelines.

o If the perpetrator/accused is a direct service provider staff person, APS investigates based upon their internal policy and guidelines.

• Health Standards Section:

o Upon receipt of an allegation or report of abuse, neglect, exploitation, or extortion by a direct service provider staff, Health Standards Section investigates based upon their internal policy and guidelines.

• Law Enforcement:

o Upon receipt of an allegation or report of abuse, neglect, or exploitation of a child that involves a direct service provider staff, law enforcement will investigate according to their policy.

• OCDD State Office (Quality Section):

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

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

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

o The LGE staff completes the participant summary for all critical incidents at the time of closure.

o The support coordinator obtains the participant summary and forwards a copy to the participant and the direct service provider within fifteen (15) days of closure by the LGE.

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

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

A multi-agency Memorandum of Understanding between OCDD and the Human Services Authorities and Districts (now referred to as the Local Governing Entity) delineates the responsibility for oversight of the reporting and response to critical incidents or events that affect waiver participants.

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

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

• OCDD generates reports on the trends and patterns in critical incident occurrence to identify potential quality enhancement goals;

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

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

o Development and review of reports to assure that follow-up and case closure of critical incidents occur according to OCDD Operational Instruction F-5.

o Quarterly analysis of data to identify trends and patterns in delivery of waiver services for effective program management that ensures the safety and well-being of people receiving OCDD supports and services.

Frequency of oversight activities:

The LGE will sample Critical Incidents to review for adherence to policy including a review to determine if all necessary actions were taken to address and resolve Critical Incidents and perform annual analysis of data to determine the effectiveness of quality enhancement goals and activities.

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

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

Appendix G: Participant Safeguards

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

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

The State does not permit or prohibits the use of restraints

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

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

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

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

Categories of restraint use:

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

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

• Seclusion is not permitted.

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

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

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

• Protective holds are only to be used in an emergency to prevent a person from causing harm to self or others and after other, less restrictive interventions/strategies have failed. Protective holds may only be implemented by trained staff and of short duration. Office for Citizens with Developmental Disabilities has a Policy on Restraint and Seclusion #701 issued March 6, 2003.

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

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

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

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

• Direct care staff are required to have initial and annual training in the management of aggressive behavior, this includes acceptable and prohibited responses, crisis de-escalation, and safe methods for

protecting the person and staff, including techniques for physically holding a person if necessary. When a participant becomes angry, verbally aggressive or highly excitable, staff will utilize this training.

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

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

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

OCDD does not support the use of restraint (which will be referred to as protective supports and procedures) as a true behavioral intervention with application contingent on exhibition of a specific problem behavior on a routine basis. Rather, it is only to be used in situations where there is immediate, imminent risk of harm to self or others if physical intervention does not occur. Protective supports and procedures are incorporated in the plan of care if use is anticipated based on the participant's behavioral trends and patterns. Behavioral challenges are addressed in an ongoing plan that utilize other appropriate and less restrictive techniques to prevent the problems, de-escalate them when they occur, and teach appropriate options/coping skills/replacement behaviors.
The direct service provider is responsible for reviewing incidents and trends while OCDD is responsible for reviewing direct service provider practices and use of protective supports and procedures. Incidents reaching a specified threshold will be reviewed by the OCDD Clinical Review Committee.

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

Preventive strategy examples:

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

Teaching examples:

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

Intervention examples:

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

Again, it should be noted that these are only examples in each category of possible strategies. There are many other alternatives that may be used. Each plan is tailored to meet the participant's needs and is developed by different professionals.
The use of restraints requires prior permission. Informed consent is obtained from the participant or his/her legal guardian relevant to the participant's consent for implementation of the plan. At a minimum, informed consent includes the essential components necessary for understanding the potential risks and benefits of the plan. Also, the participant or legal guardian shall be informed of the right to withhold or withdraw consent at any time. If a restraint is unplanned, as in emergency situations, prior

permission is not obtained. However, unplanned restraints are based on the fact that the restraint is a response to an emergent situation in which imminent risk of harm exists to person and/or others.

Strategies considered prior to restraint use include Positive Support Procedures (based on the individual support need), Desensitization, assessment by allied health professionals for alternate communication strategies, and identification of possible medical antecedents, etc.
When restraint is used for behavior support procedures, a licensed psychologist authorizes the use. When restraints are used for medical protective supports and procedures (as those applied as a health-related protection) a licensed physician, licensed dentist, or licensed podiatrist, authorizes the use.

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

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

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

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

•• The DHH Health Standards Section is responsible for monitoring that participant rights are observed and that there are no negative outcomes related to the use of physical or chemical restraints.

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

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

recommendations.

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

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

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

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

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

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

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

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

c. **Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The State does not permit or prohibits the use of seclusion

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

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

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

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

Appendix G: Participant Safeguards

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

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

a. **Applicability.** Select one:

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

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

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

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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

Not applicable. *(do not complete the remaining items)*

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

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

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

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

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

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

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

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

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

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
G.a.i.a.1. Number and percentage of abuse, neglect or exploitation cases that are substantiated by Protective Services where required remediation is completed as measured by case closure. Numerator = Number of substantiated incidents of abuse, neglect or exploitation where required remediation was completed; Denominator = Total number of substantiated allegations.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G.a.i.a.2. Number and percentage of deaths requiring a corrective action plan where the corrective action plan was completed as measured by closure of the critical incident. Numerator = Number of deaths requiring a corrective action plan where the corrective action plan was completed; Denominator = Total number of deaths requiring corrective action plan.

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

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

collection/generation *(check each that applies):*		
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☑ Representative Sample Confidence Interval = 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.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**

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.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 = 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.5. Number and percentage of reported use of restraints where appropriate follow-up has been completed as measured by case closure. Numerator = Number of reported use of restraints where appropriate follow-up has been completed as measured by case closure; Denominator = Total number of reported use of restraints.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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.
OCDD Operational Instruction F-5: Critical Incident Reporting, Tracking and Follow-up Activities for Waiver Services provides instruction for multiple levels of addressing waiver participant problems as they are discovered.

Primary remediation occurs at the level of the direct care provider agency, where immediate response is required in correcting harmful, dangerous or potentially harmful or dangerous conditions at the time the condition is discovered. General methods of remediation may include notification and involvement of the participant's legal guardian or authorized representative, removal or cessation of the harmful condition, obtaining appropriate medical assistance, replacing a paid direct service worker if appropriate, and contacting law enforcement and/or protective services. The direct care provider is also responsible for reporting the incident to the support coordinator within established timelines for inclusion in the OTIS system and to provide the support coordinator with necessary information for further action to remediate the problem.

The support coordinator is responsible for determining any further remediation that can be implemented by way of strategies developed in team meetings with the participant and axillary support services. All follow-up remediation at this level is to be documented in the OTIS case notes.

The LGE waiver offices are responsible for reviewing individual OTIS cases on a daily basis and assuring that support coordinators follow through as described in the previous paragraph. The LGE provides technical support to support coordinators as necessary and also make referrals to OCDD for incidents involving risk management or death. The LGE also serves as the liaisons with support coordinators for any remediation recommendations from the OCDD. All follow-up remediation at this level as well as recommendations from OCDD review committees is documented in the OTIS case file by the LGE.

The OCDD conducts individual reviews of incidents involving waiver participants that meet the threshold

for involvement at that level as required in OCDD Operational Instruction F-8:Risk Management Process for Waiver Services: Critical incident Reviews, and generates recommendations to the LGE where each participant resides to further assist in remediation. Documentation of the recommendations is electronically forwarded to the LGE on a standard form.

Remediation of individual cases of substantiated abuse, neglect or exploitation is determined by the appropriate protective services agency (dependent on the waiver participant's age) and/or the DHH Health Standards Section as required in their policies and procedures. Findings and recommendations are entered into the OTIS case file and the process for follow-up is conducted by the LGE, support coordinator and provider agency as described above. In cases where Health Standards substantiates Immediate Jeopardy conditions, remediation must be accomplished by the direct service provider prior to Health Standards exiting the investigation.

The OCDD conducts individual reviews of all incidents resulting in the death of the waiver participant as described in OCDD Operational Instruction F-1: Mortality Review Process. If Health Standards and /or the appropriate protective service agency do not substantiate abuse or neglect and recommendation remediation to protect other participants in the care of the targeted direct care provider agency, OCDD may still determine a death was preventable, and require a corrective action plan from the LGE, the support coordinator or the direct service provider. The OCDD Mortality Review Committee maintains a record of the findings of each mortality review and issues requests for Corrective Action Plans on a standard form to the LGE, who then document the information in the individual OTIS case notes. Follow-up corrective action is also documented in the case file.

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, LGE, OCDD State Office, and BHSF) within the system is required to design and implement a Quality Management Strategy.
Meet with Office of Aging and Adult Services (OAAS), the office within 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.

LGE Processes:

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

OCDD State Office Processes:

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

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

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

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

- Adult Day Health Care Waiver
- Community Choices Waiver
  New Opportunities Waiver
- Residential Options Waiver
  Children's Choice Waiver

Several cross agency work groups comprise the cross waiver Quality Improvement System. The mission, composition and major tasks of each entity represented under the QIS are described below.
Cross-Waiver Stakeholder Advisory Committee meets twice a year. Members include Medicaid Program

Support and Waivers (MPSW), Adult Protective Services (APS), state operating agencies (Office for Citizens with Developmental Disabilities and Office of Aging Supports and Services), consumers, providers, and advocates. The mission of the group is to:

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

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

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

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

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

ii. System Improvement Activities

Responsible Party*(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 Process:

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

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

OCDD Process:

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

BHSF Process:

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

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

Appendix I: Financial Accountability

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 Supports Waiver providers. Audits are conducted based on complaints from all sources. SURS also conducts data mining activities of all provider types in order to detect suspicious billing activities. Based on the complaints made and data mining conducted, individual cases are opened and investigated or Self-Audit

notices are sent out to providers. Post-payment reviews in the Program Integrity function is based upon evidence revealed as a result of production runs, data mining runs, projects, complaints, referrals, and other SUR function activities. Random audits are also performed.

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

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

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

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

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

Responsible Party for data collection/generation *(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: 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**

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

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

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

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

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

Performance Measures

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
I.a.1.On an individual's plan of care, all waiver services codes are listed. Only those waiver services codes listed are prior authorized. Those services which have a hard cap are prior authorized with a hard cap. Services with a soft cap require OCDD and/or LGE override. The Medicaid data contractor's system does not allow the provider to bill for more than the service which is prior authorized. However, if services are prior authorized and are billed by the provider for the cap and later reduced, the provider could receive payment for more services than are PA'd.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
I.a.1 and I.a.2: BHSF/MSPW will require OCDD to mandate that the provider void claims within specified period of time. Failure to do so by provider may result in further action such as referral to Program Integrity, withholding future payments until correction made, and training as necessary. In the event that problem appears to be systemic in nature, MSPW will require corrective action by OCDD including training of providers.

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

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

The Office of Citizens with Developmental Disabilities (OCDD) determines the rates of payment for services. Service rates are promulgated by Medicaid through a rulemaking process, which includes opportunity for public input through written comments, which are entered into record, and a public hearing, where comments may be read into record. This process affords Medicaid oversight of the rate determination process.

Rates for Supported Employment, Day Habilitation, and Prevocational were based on ten years of historic usage of these services, and costs of providing these services as evidenced by data from a 3 year pilot project in which nine small, medium and large, urban and rural state general funded contracted Vocational and Habilitation Providers participated. The project broke down line item costs for each approved cost category, as well as showing specific individual's outlier costs each month. Information from the project was shared with all current state general funded Vocational and Habilitation providers, and other stakeholders. The Rates Subcommittee used this information to develop the specific rates for these three services.

The Rates Subcommittee set Respite and Habilitation rates at the current rate being paid through the New Opportunities Waiver (NOW) for Individual and Family Support (which includes Respite and Personal Care Attendant services). Family members requested that the compensation for these two services remain at the current

NOW rate in order to attract quality staff. The NOW waiver rates were defined by actual service costs, reviewed and approved by the NOW stakeholder group.

The cost of Personal Emergency Response System is based on actual utilization costs from 239 providers of the service over a 12 month period.

The cost of Support Coordination services are based upon the provider cost of rendering the service and then adjusted based on the availability of state funding or DHH's ability to secure appropriation.

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

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

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

Appendix I: Financial Accountability

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

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

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

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

***Select at least one*:**

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

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

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

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

Appendix I: Financial Accountability

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

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

•OCDD will use a prior authorization and post authorization system to insure that services provided and paid for are in accordance with the Plan of Care (POC).
Medicaid eligibility for services is checked and reviewed by the prior authorization entity. The Supports Waiver uses a system of prior and post authorization to ensure that services provided to waiver participants are provided in the scope, duration, and frequency as outlined in the participants plan of care. Services are prior authorized by the POC in quarterly increments and post authorized for payment after services have been rendered. DHH currently uses a contracted entity for its prior and post-authorizations.
All Medicaid waiver services are paid through prior authorization. Before any payments are made for Medicaid services, the participant is checked for eligibility for waiver services by the state fiscal intermediary. If the date of service matches Medicaid and waiver eligibility, then the claim is paid. If not, the claim is denied and a denial code of service ineligibility is given for the claim.

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

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

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

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

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

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

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

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

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:

- ☐ **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:

State Developmental Centers, which are public ICF/DDs currently provide Supported Employment, Day Habilitation, and Prevocational Rehabilitation to waiver participants. A State Developmental Center may provide any of the services in the Supports Waiver as long as they obtain the appropriate license, and enroll as a waiver provider of the specific service(s).

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*:

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

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

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

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

Appendix I: Financial Accountability

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

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

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

Check each that applies:

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

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

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

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

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

Appendix I: Financial Accountability

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

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

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

The following source(s) are used

Check each that applies:

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

☐ **Provider-related donations**

☐ **Federal funds**

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

Appendix I: Financial Accountability

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

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

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

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

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

Do not complete this item.

Appendix I: Financial Accountability

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

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

No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

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

Appendix I: Financial Accountability

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

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

No. The State does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

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

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

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

Specify:

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

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

Appendix I: Financial Accountability

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

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

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

○ **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

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

Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	6956.57	4965.00	11921.57	81170.00	4029.00	85199.00	73277.43
2	6956.57	5014.65	11971.22	81981.70	4170.02	86151.72	74180.50

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)
3	6956.57	5064.80	12021.37	82801.52	4315.97	87117.49	75096.12
4	6956.57	5115.44	12072.01	83629.53	4467.02	88096.55	76024.54
5	6956.57	5166.60	12123.17	84465.83	4623.37	89089.20	76966.03

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	2500	2500
Year 2	2500	2500
Year 3	2500	2500
Year 4	2500	2500
Year 5	2500	2500

Appendix J: Cost Neutrality Demonstration

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

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

The proposed average length of stay is an estimate based on historic utilization of state general funded vocational and habilitation services taken in conjunction with the phase-in plan. Each subsequent year, the average length of stay estimate will be based on total number of days of waiver eligibility of all support waiver participants divided by the number of unduplicated recipients over the waiver plan year as indicated from prior year data.

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 estimates are based on estimated program utilization data for the number of unduplicated participants, and services per participant for each service in the waiver.
Program utilization data was obtained from 5 years of monthly reports on individual's usage of the various services through state general funded programs. Multiplying these estimates by actual service rates derives an estimated cost per service. This dollar amount is then totaled and divided by the number of unduplicated participants for an average cost per participant. A utilization inflation factor is thereby applied to each subsequent year based on program history and other factors.

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

Factor D' is an estimate based on the actual participant expenditures for all other Medicaid services outside of waiver services. This dollar amount is totaled and then divided by the number of waiver participants to get an estimated average cost. A utilization inflation factor is thereby applied to each subsequent year based on state general funded vocational and habilitation program history and other factors. Medicare Part D recipients who participate in this waiver will be identified through their designated eligibility criteria. All related pharmacy expenditures related to these recipients will be deducted from the total acute Medicaid expenditures before the calculation of the average cost.

Factor D' is less than Factor G' in the Supports Waiver for two reasons. First, the acuity levels of individuals in Louisiana's ICF/DDs are greater than those in the community. As a result, there are greater expenditures for persons in institutions for acute care, particularly for inpatient hospital stays as well as prescription drugs. Secondly, the Supports Waiver participants are higher functioning individuals as evidenced by their participation in vocational training and employment, and other activities. Generally, the Supports Waiver population have fewer inpatient hospital stays, far less prescription drug costs, and enjoy better overall health.

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

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

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

Factor G' is an estimate based on the actual Medicaid expenditures for all other Medicaid services provided to citizens residing in intermediate care facilities for the mentally retarded (ICF/MR). This dollar amount is totaled and then divided by the number of waiver recipients to get an estimated average cost. A utilization inflation factor is thereby applied to each subsequent year based on program history and other factors. Medicare Part D recipients who are served in ICF/MRs will be identified through their designated eligibility criteria. All related pharmacy expenditures related to these recipients will be deducted from the total acute Medicaid expenditures before the calculation of the average cost.

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	
Day Habilitation	
Habilitation	
Prevocational Services	
Respite	
Support Coordination	
Supported Employment	
Housing Stabilization Service	
Housing Stabilization Transition Service	
Personal Emergency Response System	

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
Day Habilitation Total:						1310839.20
Day Habilitation	15 minute	180	2452.00	2.97	1310839.20	
Habilitation Total:						400851.36
Habilitation	15 minute	644	171.00	3.64	400851.36	
Prevocational Services Total:						5071449.60
Prevocational Services	15 minute	662	2880.00	2.66	5071449.60	
Respite Total:						516114.56
Respite	15 minute	533	272.00	3.56	516114.56	
Support Coordination Total:						4169853.60
Support Coordination	monthly	2490	11.00	152.24	4169853.60	
Supported Employment Total:						5835251.24
Supported Employment	15 minute	689	596.00	14.21	5835251.24	
Housing Stabilization Service Total:						39331.33
Housing Stabilization Service	15 minutes	19	137.00	15.11	39331.33	
Housing Stabilization Transition Service Total:						7071.48
Housing Stabilization Transition Service	15 minutes	3	156.00	15.11	7071.48	
Personal Emergency Response System Total:						40673.93
Personal Emergency Response System	monthly	137	11.00	26.99	40673.93	
				GRAND TOTAL:		17391436.30
				Total Estimated Unduplicated Participants:		2500
				Factor D (Divide total by number of participants):		6956.57
				Average Length of Stay on the Waiver:		310

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						1310839.20
Day Habilitation	15 minute	180	2452.00	2.97	1310839.20	
Habilitation Total:						400851.36
Habilitation	15 minute	644	171.00	3.64	400851.36	
Prevocational Services Total:						5071449.60
Prevocational Services	15 minute	662	2880.00	2.66	5071449.60	
Respite Total:						516114.56
Respite	15 minute	533	272.00	3.56	516114.56	
Support Coordination Total:						4169853.60
Support Coordination	monthly	2490	11.00	152.24	4169853.60	
Supported Employment Total:						5835251.24
Supported Employment	15 minute	689	596.00	14.21	5835251.24	
Housing Stabilization Service Total:						39331.33
Housing Stabilization Service	15 minutes	19	137.00	15.11	39331.33	
Housing Stabilization Transition Service Total:						7071.48
Housing Stabilization Transition Service	15 minutes	3	156.00	15.11	7071.48	
Personal Emergency Response System Total:						40673.93
Personal Emergency Response System	monthly	137	11.00	26.99	40673.93	
				GRAND TOTAL:		17391436.30
				Total Estimated Unduplicated Participants:		2500
				Factor D (Divide total by number of participants):		6956.57
				Average Length of Stay on the Waiver:		310

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						1310839.20
Day Habilitation	15 minute	180	2452.00	2.97	1310839.20	
Habilitation Total:						400851.36
Habilitation	15 minute	644	171.00	3.64	400851.36	
Prevocational Services Total:						5071449.60
Prevocational Services	15 minute	662	2880.00	2.66	5071449.60	
Respite Total:						516114.56
Respite	15 minute	533	272.00	3.56	516114.56	
Support Coordination Total:						4169853.60
Support Coordination	monthly	2490	11.00	152.24	4169853.60	
Supported Employment Total:						5835251.24
Supported Employment	15 minute	689	596.00	14.21	5835251.24	
Housing Stabilization Service Total:						39331.33
Housing Stabilization Service	15 minutes	19	137.00	15.11	39331.33	
Housing Stabilization Transition Service Total:						7071.48
Housing Stabilization Transition Service	15 minutes	3	156.00	15.11	7071.48	
Personal Emergency Response System Total:						40673.93
Personal Emergency Response System	monthly	137	11.00	26.99	40673.93	
				GRAND TOTAL:		17391436.30
				Total Estimated Unduplicated Participants:		2500
				Factor D (Divide total by number of participants):		6956.57
				Average Length of Stay on the Waiver:		310

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**1310839.20**
Day Habilitation	15 minute	180	2452.00	2.97	**1310839.20**	
Habilitation Total:						**400851.36**
Habilitation	15 minute	644	171.00	3.64	**400851.36**	
Prevocational Services Total:						**5071449.60**
Prevocational Services	15 minute	662	2880.00	2.66	**5071449.60**	
Respite Total:						**516114.56**
Respite	15 minute	533	272.00	3.56	**516114.56**	
Support Coordination Total:						**4169853.60**
Support Coordination	monthly	2490	11.00	152.24	**4169853.60**	
Supported Employment Total:						**5835251.24**
Supported Employment	15 minute	689	596.00	14.21	**5835251.24**	
Housing Stabilization Service Total:						**39331.33**
Housing Stabilization Service	15 minutes	19	137.00	15.11	**39331.33**	
Housing Stabilization Transition Service Total:						**7071.48**
Housing Stabilization Transition Service	15 minutes	3	156.00	15.11	**7071.48**	
Personal Emergency Response System Total:						**40673.93**
Personal Emergency Response System	monthly	137	11.00	26.99	**40673.93**	
				GRAND TOTAL:		**17391436.30**
				Total Estimated Unduplicated Participants:		**2500**
				Factor D (Divide total by number of participants):		**6956.57**
				Average Length of Stay on the Waiver:		310

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						1310839.20
Day Habilitation	15 minute	180	2452.00	2.97	1310839.20	
Habilitation Total:						400851.36
Habilitation	15 minute	644	171.00	3.64	400851.36	
Prevocational Services Total:						5071449.60
Prevocational Services	15 minute	662	2880.00	2.66	5071449.60	
Respite Total:						516114.56
Respite	15 minute	533	272.00	3.56	516114.56	
Support Coordination Total:						4169853.60
Support Coordination	monthly	2490	11.00	152.24	4169853.60	
Supported Employment Total:						5835251.24
Supported Employment	15 minute	689	596.00	14.21	5835251.24	
Housing Stabilization Service Total:						39331.33
Housing Stabilization Service	15 minutes	19	137.00	15.11	39331.33	
Housing Stabilization Transition Service Total:						7071.48
Housing Stabilization Transition Service	15 minutes	3	156.00	15.11	7071.48	
Personal Emergency Response System Total:						40673.93
Personal Emergency Response System	monthly	137	11.00	26.99	40673.93	
				GRAND TOTAL:		17391436.30
				Total Estimated Unduplicated Participants:		2500
				Factor D (Divide total by number of participants):		6956.57
				Average Length of Stay on the Waiver:		310