

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver’s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State of Alaska** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
People with Intellectual and Developmental Disabilities

C. Waiver Number:AK.0260
Original Base Waiver Number: AK.0260.90.R2

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)

01/01/17

Approved Effective Date of Waiver being Amended: 07/01/16

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
 The purpose of this amendment is threefold:

- 1) To amend the unduplicated recipient count in Appendix B-3-a and Appendix J-2-d to better align with current estimate for the number of unduplicated recipients to receive waiver services in FY17.
- 2) To provide details in Appendix F-2 of a mediation process that will be used in advance of fair hearings.
- 3) To set an age restriction of 21+ on the Intensive Active Treatment (IAT) service in Appendix C-1/C-3 and provide a transition plan in Main-Attachment 1, as the IAT service is transitioned to a regular Medicaid EPSDT service for children and youth.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
<input type="checkbox"/> Waiver Application	
<input type="checkbox"/> Appendix A – Waiver Administration and Operation	

Component of the Approved Waiver	Subsection(s)
<input checked="" type="checkbox"/> Appendix B – Participant Access and Eligibility	B-3
<input checked="" type="checkbox"/> Appendix C – Participant Services	C-1/C-3
<input type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	
<input type="checkbox"/> Appendix E – Participant Direction of Services	
<input checked="" type="checkbox"/> Appendix F – Participant Rights	F-2
<input type="checkbox"/> Appendix G – Participant Safeguards	
<input type="checkbox"/> Appendix H	
<input type="checkbox"/> Appendix I – Financial Accountability	
<input checked="" type="checkbox"/> Appendix J – Cost-Neutrality Demonstration	J-2

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (check each that applies):

- Modify target group(s)
- Modify Medicaid eligibility
- Add/delete services
- Revise service specifications
- Revise provider qualifications
- Increase/decrease number of participants
- Revise cost neutrality demonstration
- Add participant-direction of services
- Other

Specify:

Add details in Appendix F-2 of a mediation process used in advance of the fair hearing process.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The State of Alaska requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (optional - this title will be used to locate this waiver in the finder):

People with Intellectual and Developmental Disabilities

C. Type of Request: amendment

Requested Approval Period: (For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)

- 3 years 5 years

Original Base Waiver Number: AK.0260

Draft ID: AK.006.05.01

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/16

Approved Effective Date of Waiver being Amended: 07/01/16

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (check each that applies):

- Hospital

Address 2:	<input type="text"/>
City:	<input type="text"/>
State:	Alaska
Zip:	<input type="text"/>
Phone:	<input type="text"/> Ext: <input type="text"/> <input type="checkbox"/> TTY
Fax:	<input type="text"/>
E-mail:	<input type="text"/>
Attachments	<input type="text"/>

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- Replacing an approved waiver with this waiver.
- Combining waivers.
- Splitting one waiver into two waivers.
- Eliminating a service.
- Adding or decreasing an individual cost limit pertaining to eligibility.
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- Reducing the unduplicated count of participants (Factor C).
- Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

A draft State Plan Amendment adding Intensive Active Treatment (IAT) as a regular Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service was submitted to CMS in mid-September, and the Division of Behavioral Health (DBH) is responding to informal questions from CMS. DBH is also preparing regulatory amendments and communicating with the Division of Health Care Services (DHCS) about changes to the Medicaid Management Information System (MMIS) about billing codes, provider enrollment and training. Tribal consultation will commence when regulations are issued for public comment.

For recipients of IAT, the transitions should be fairly seamless, as the providers and payment rates are expected to remain the same. SDS has already notified each the recipients of IAT who will be affected by this change (there are fewer than 20, and none of them are nearing age 21) and their care coordinators about the removal of IAT as a waiver service, the anticipated timing for IAT to become regular Medicaid State Plan service, and how the transition will work. DBH plans to contract with an independent Board Certified Behavioral Analyst (BCBA) to conduct all initial and review assessments. ABA regulations will stipulate that all current ABA recipients will require a new assessment and families will have three months to obtain this new assessment. If a current ABA recipient no longer qualifies due to the results of the assessment the family will be notified and have opportunity to appeal the decision. Additional information, including information on the opportunity to request a Fair Hearing, will be relayed in November and December, via letters, phone calls and communications with care coordinators. DBH is prepared to absorb 100% of the cost of paying providers to provide IAT services to recipients with a medical need until the SPA, regulations and MMIS are amended and the service is available through EPSDT. The IAT service will be renamed Applied Behavioral Analysis (ABA) when offered through DBH, once

the amendment is approved by CMS with an effective date.

During the period when IAT is no longer a waiver service and until it becomes ABA as a Medicaid service, DBH will have both providers of IAT (there are currently only two) complete contracts with DBH to provide ABA Services. As contract providers, the two will be provided access to AKAIMS, which will be utilized as both the Electronic Health Record (EHR) as well as the billing system for the next six months, or until the MMIS is set up to accept ABA service billings. Funds utilized to pay for ABA between the period beginning with the effective date of this amendment through June 30, 2017 will be State General Funds. ABA services will be provided to any children who may become IDD Waiver-eligible during this time frame and qualify for ABA Services.

DBH staff will review and adjudicate all claims submitted through AKAIMS.

Upon the completion of system changes to the MMIS, DBH will request the Division of Health Care Services (DHCS) run all paid claims through the MMIS to capture the Federal Medicaid match. This match will be reimbursed to the General Fund.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301 (c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The State assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to this waiver when it submits the next amendment or renewal.

Systemic Review of State Statutes and Regulations

To gauge the extent to which current state regulations ensure compliance with federal setting requirements, SDS reviewed state statutes and regulations governing Medicaid waiver services, assisted living home licensing, foster care licensing, and the home and community-based services provider standards in the SDS Conditions of Participation.

Because SDS refined its philosophy and practices, including updating its regulations and policies, as new directives were issued, SDS concludes that the state regulations and policies applicable to waiver services are consistent with the new federal regulations, and support integrated settings, full access to the community, and recipient initiative, autonomy, and independence; nonetheless, SDS finds that the requirements regarding settings can be clarified through additional language in SDS regulations and Conditions of Participation, as outlined in Part 3, the State Plan for Achieving Compliance section. This language will also amend regulations found by SDS and CMS to be "silent" on settings requirements.

The Department of Health and Human Services will establish a stakeholder group called the interagency settings compliance committee (ISCC). ISCC will have a person-centered focus that is transparent to participants and the community while providing accountability to all parties involved. The overarching mission for the ISCC will be to ensure that the State is not only in compliance with the CMS settings rule but also that the rule is ingrained in the practice of HCBS providers.

The purpose of this committee is to:

- Evaluate State Statute and Regulations to ensure compliance with CMS Rule

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

- The participant is referred to another waiver that can accommodate the individual's needs.**
- Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	2200
Year 2	2180
Year 3	2160
Year 4	2140
Year 5	2120

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: (*select one*):

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Upon approval of the amendment, Intensive Active Treatment (IAT) will assist participants ages 21 and older who need immediate intervention to treat a medical or decelerate behavior regression that, if left untreated, would place the recipient at risk of institutionalization. (Children and youth up to age 21 are entitled to receive IAT as a regular Medicaid EPSDT service, so upon approval of this amendment. IAT will not be available as a waiver service to children and youth.) IAT is provided by a professional licensed under AS 08, a paraprofessional supervised by that professional and licensed under AS 08 if required, or an individual certified under AS 14.20.010 with a special education endorsement under 4 AAC 12.330. Providers of IAT must submit contemporaneous documentation indicating that IAT services provide specific treatment or therapy needed to maintain or improve effective function of the participant, that the intervention is time-limited and addresses the participant's specific personal, family, social, behavioral or psychiatric problem, and that each intervention requires the precision and knowledge possessed only by specially-trained professionals in specific disciplines whose services are not covered under Medicaid or as habilitation services under 7 AAC 130.260. IAT services do not include training and oversight of other direct service providers or monitoring of other health-related home and community-based waiver services.

IAT services are provided in the offices of the professionals providing the interventions, so the setting is the same as the setting for services provided to the greater community of non-disabled people, with occasional service provided in the recipient's natural setting to ensure that the skills are being transferred appropriately.

All IAT services must be prior authorized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

none

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified home and community-based service agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Intensive Active Treatment

Provider Category:

(DHCS) will provide assistance in obtaining representation, preparing the case, and gathering witnesses and/or documents to be used in presenting the claim.

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.

The State offers a process for mediation in advance of fair hearing to address disputes in regards to all services provided through SDS.

(a) State Agency Operating the Process: Mediation services are provided by a third party contractor who is a lawyer and who operates under the Office of Administrative Hearings (OAH) within Department of Administration.

(b) Procedures and Timeframe: Recipients (or care coordinators of behalf of recipients) that have requested a fair hearing are automatically scheduled for an informal mediation session. OAH sends a notice to the appellant with a date and time for the informal mediation session, generally 10 days from the time OAH receives the case referral. A Calendar Call (a short scheduling conference to set a date and time for the fair hearing if the case is not settled in mediation) is also identified within this notice. The notice also states that the mediation is voluntary, is not a pre-requisite or substitute for a fair hearing, and that the appellant retains the right to a fair hearing if the disputes are not resolved during the mediation, as set forth in 7AAC 49.010, Chapter 49 Hearings. Appellants can let the OAH know at any time up to and during the mediation session that they do not want to pursue settlement through mediation.

In addition, both the appellant and the State may request a formal mediation in which an Administrative Law Judge, who is not assigned to preside over the case, will act as a mediator. Both parties have to agree to undergo a formal mediation, and the mediator will make a recommendation for settlement. Use of formal mediation does not preclude the right to a Fair Hearing if the disputes are not resolved during the informal or formal mediation, as set forth in 7AAC 49.010, Chapter 49 Hearings.

Types of Disputes: During both the informal and formal mediation sessions, the parties may discuss new information including medical documentation and other potential environmental changes, and how these affect the appellant's eligibility for Level of Care or specific services. The types of disputes addressed through this mediation process include initial waiver denial, material improvement and waiver termination decisions, eligibility for services such as chore, respite, and day habilitation, determination of developmental disability decisions, denials of enhanced payments for acuity, and any disagreements stated by the appellant which are addressed in the state's notice authorizing or denying services. Any matters discussed during mediation remain confidential. Partial resolutions are allowable, if documented, and remaining unresolved issues can proceed to fair hearing.

(c) Preserving Right to Fair Hearing: The appellant retains the right to a fair hearing if the disputes are not resolved during informal or formal mediation, as set forth in 7AAC 49.010, Chapter 49 Hearings. The appellant has the ability to bypass mediation and continue to schedule a fair hearing at any time during this process.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

Factor G' reflects the actual non-institution Medicaid expenses for service recipients of the Alaska's sole ICFIID that was closed in 1995, as documented through the previous waiver application. A 2.4% increase was applied for each subsequent year to reflect inflation.

The State uses actual Medicaid claims data to estimate future Medicaid expenses for Factor G' and Factor D'. The forecasting of Factor D' (regular Medicaid expenses for waiver participants) being lower than G' (regular Medicaid expenses for the comparison institutionalized population) reflects that people who remain in their homes and communities do not use as many regular medical services as people who reside institutions.

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	
Care Coordination	
Day Habilitation	
Residential Habilitation	
Respite	
Supported Employment	
Chore	
Environmental Modifications	
Intensive Active Treatment	
Meals	
Nursing Oversight and Care Management	
Specialized Medical Equipment	
Specialized Private Duty Nursing	
Transportation	

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
Care Coordination Total:						7217232.00
Care Coordination	1 month	2200	12.00	273.38	7217232.00	
Day Habilitation Total:						
GRAND TOTAL:						170972153.46
Total Estimated Unduplicated Participants:						2200
Factor D (Divide total by number of participants):						77714.62
Average Length of Stay on the Waiver:						335

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						31807302.45
Individual Day Habilitation	15 minutes	1752	1315.00	11.62	26771085.60	
Group Day Habilitation	15 minutes	621	1015.00	7.99	5036216.85	
Residential Habilitation Total:						117312691.52
residential habilitation	15 minutes	980	3116.00	11.70	35728056.00	
residential habilitation	daily	824	314.00	315.32	81584635.52	
Respite Total:						4784545.76
respite	daily	308	8.00	317.54	782418.56	
respite	15 minutes	724	830.00	6.66	4002127.20	
Supported Employment Total:						8337356.20
Individual Supported Employment	15 minutes	321	1256.00	13.10	5281605.60	
Group Supported Employment	15 minutes	217	1556.00	9.05	3055750.60	
Chore Total:						21587.40
Chore	15 min.	9	335.00	7.16	21587.40	
Environmental Modifications Total:						79705.62
Environmental Modifications	per project	9	2.00	4428.09	79705.62	
Intensive Active Treatment Total:						695264.08
Intensive Active Treatment	15 min.	56	521.00	23.83	695264.08	
Meals Total:						49183.68
Meals	per meal	12	182.00	22.52	49183.68	
Nursing Oversight and Care Management Total:						336954.27
Nursing Oversight and Care Management	15 min.	83	131.00	30.99	336954.27	
Specialized Medical Equipment Total:						24219.90
Specialized Medical Equipment	per item	17	10.00	142.47	24219.90	
GRAND TOTAL:						170972153.46
Total Estimated Unduplicated Participants:						2200
Factor D (Divide total by number of participants):						77714.62
Average Length of Stay on the Waiver:						335

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Private Duty Nursing Total:						51707.22
Specialized Private Duty Nursing	15 minutes	2	1263.00	20.47	51707.22	
Transportation Total:						254403.36
Transportation	per ride	82	124.00	25.02	254403.36	
GRAND TOTAL:						170972153.46
Total Estimated Unduplicated Participants:						2200
Factor D (Divide total by number of participants):						77714.62
Average Length of Stay on the Waiver:						335

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
Care Coordination Total:						7323230.40
Care Coordination	1 month	2180	12.00	279.94	7323230.40	
Day Habilitation Total:						32280259.20
Individual Day Habilitation	15 minutes	1736	1315.00	11.90	27165796.00	
Group Day Habilitation	15 minutes	616	1015.00	8.18	5114463.20	
Residential Habilitation Total:						119078108.72
residential habilitation	15 min.	971	3116.00	11.98	36247119.28	
residential habilitation	daily	817	314.00	322.88	82830989.44	
Respite Total:						4852040.60
respite	daily	305	8.00	325.16	793390.40	
respite	15 minutes	717	830.00	6.82	4058650.20	
GRAND TOTAL:						173533069.13
Total Estimated Unduplicated Participants:						2180
Factor D (Divide total by number of participants):						79602.33
Average Length of Stay on the Waiver:						335

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment Total:						8457247.08
Individual Supported Employment	15 minutes	318	1256.00	13.41	5356061.28	
Group Supported Employment	15 minutes	215	1556.00	9.27	3101185.80	
Chore Total:						22099.95
Chore	15 min.	9	335.00	7.33	22099.95	
Environmental Modifications Total:						81618.48
Environmental Modifications	per project	9	2.00	4534.36	81618.48	
Intensive Active Treatment Total:						712186.16
Intensive Active Treatment	15 min.	56	521.00	24.41	712186.16	
Meals Total:						50363.04
Meals	per meal	12	182.00	23.06	50363.04	
Nursing Oversight and Care Management Total:						340843.66
Nursing Oversight and Care Management	15 min.	82	131.00	31.73	340843.66	
Specialized Medical Equipment Total:						24799.60
Specialized Medical Equipment	per unit	17	10.00	145.88	24799.60	
Specialized Private Duty Nursing Total:						52944.96
Specialized Private Duty Nursing	15 minutes	2	1263.00	20.96	52944.96	
Transportation Total:						257327.28
Transportation	per ride	81	124.00	25.62	257327.28	
GRAND TOTAL:						173533069.13
Total Estimated Unduplicated Participants:						2180
Factor D (Divide total by number of participants):						79602.33
Average Length of Stay on the Waiver:						335

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
Care Coordination Total:						7430227.20
Care Coordination	1 month	2160	12.00	286.66	7430227.20	
Day Habilitation Total:						32753627.50
Individual Day Habilitation	15 minutes	1720	1315.00	12.19	27571342.00	
Group Day Habilitation	15 minutes	610	1015.00	8.37	5182285.50	
Residential Habilitation Total:						120739094.30
residential habilitation	15 min	962	3116.00	12.26	36750477.92	
residential habilitation	daily	809	314.00	330.63	83988616.38	
Respite Total:						4929440.06
respite	per diem	302	8.00	332.96	804431.36	
respite	15 minutes	711	830.00	6.99	4125008.70	
Supported Employment Total:						8581345.32
Individual Supported Employment	15 minutes	315	1256.00	13.74	5436093.60	
Group Supported Employment	15 minutes	213	1556.00	9.49	3145251.72	
Chore Total:						20126.80
Chore	15 min	8	335.00	7.51	20126.80	
Environmental Modifications Total:						74291.04
Environmental Modifications	per project	8	2.00	4643.19	74291.04	
Intensive Active Treatment Total:						716088.45
Intensive Active Treatment	15 min.	55	521.00	24.99	716088.45	
Meals Total:						51586.08
Meals	per meal	12	182.00	23.62	51586.08	
Nursing Oversight and Care Management Total:						349115.00
Nursing Oversight and Care Management	15 min.	82	131.00	32.50	349115.00	
GRAND TOTAL:						175988100.57
Total Estimated Unduplicated Participants:						2160
Factor D (Divide total by number of participants):						81475.97
Average Length of Stay on the Waiver:						335

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment Total:						25396.30
Specialized Medical Equipment	1 unit	17	10.00	149.39	25396.30	
Specialized Private Duty Nursing Total:						54207.96
Specialized Private Duty Nursing	15 minutes	2	1263.00	21.46	54207.96	
Transportation Total:						263554.56
Transportation	per ride	81	124.00	26.24	263554.56	
GRAND TOTAL:						175988100.57
Total Estimated Unduplicated Participants:						2160
Factor D (Divide total by number of participants):						81475.97
Average Length of Stay on the Waiver:						335

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
Care Coordination Total:						7538107.20
Care Coordination	1 month	2140	12.00	293.54	7538107.20	
Day Habilitation Total:						33218609.00
Individual Day Habilitation	15 minutes	1704	1315.00	12.48	27964684.80	
Group Day Habilitation	15 minutes	604	1015.00	8.57	5253924.20	
Residential Habilitation Total:						122558928.84
residential habilitation	15 min	953	3116.00	12.56	37297522.88	
residential habilitation	daily	802	314.00	338.57	85261405.96	
Respite Total:						4996168.00
respite					818280.00	
GRAND TOTAL:						178600668.15
Total Estimated Unduplicated Participants:						2140
Factor D (Divide total by number of participants):						83458.26
Average Length of Stay on the Waiver:						335

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	per diem	300	8.00	340.95		
respite	15 minutes	704	830.00	7.15	4177888.00	
Supported Employment Total:						8704870.56
Individual Supported Employment	15 minutes	312	1256.00	14.07	5513639.04	
Group Supported Employment	15 minutes	211	1556.00	9.72	3191231.52	
Chore Total:						20609.20
Chore	15 min	8	335.00	7.69	20609.20	
Environmental Modifications Total:						76073.92
Environmental Modifications	per project	8	2.00	4754.62	76073.92	
Intensive Active Treatment Total:						733281.45
Intensive Active Treatment	15 min.	55	521.00	25.59	733281.45	
Meals Total:						52809.12
Meals	per meal	12	182.00	24.18	52809.12	
Nursing Oversight and Care Management Total:						353134.08
Nursing Oversight and Care Management	15 min.	81	131.00	33.28	353134.08	
Specialized Medical Equipment Total:						26004.90
Specialized Medical Equipment	1 unit	17	10.00	152.97	26004.90	
Specialized Private Duty Nursing Total:						55521.48
Specialized Private Duty Nursing	15 minutes	2	1263.00	21.98	55521.48	
Transportation Total:						266550.40
Transportation	per ride	80	124.00	26.87	266550.40	
GRAND TOTAL:						178600668.15
Total Estimated Unduplicated Participants:						2140
Factor D (Divide total by number of participants):						83458.26
Average Length of Stay on the Waiver:						335

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
Care Coordination Total:						7646755.20
Care Coordination	1 month	2120	12.00	300.58	7646755.20	
Day Habilitation Total:						33706129.90
Individual Day Habilitation	15 minutes	1688	1315.00	12.78	28368021.60	
Group Day Habilitation	15 minutes	599	1015.00	8.78	5338108.30	
Residential Habilitation Total:						124263105.48
residential habilitation	15 min.	944	3116.00	12.86	37827741.44	
residential habilitation	daily	794	314.00	346.69	86435364.04	
Respite Total:						5076118.84
respite	per diem	297	8.00	349.14	829556.64	
respite	15 minutes	698	830.00	7.33	4246562.20	
Supported Employment Total:						8824477.40
Individual Supported Employment	15 minutes	309	1256.00	14.40	5588697.60	
Group Supported Employment	15 minutes	209	1556.00	9.95	3235779.80	
Chore Total:						21091.60
Chore	15 min.	8	335.00	7.87	21091.60	
Environmental Modifications Total:						77899.68
Environmental Modifications	per project	8	2.00	4868.73	77899.68	
Intensive Active Treatment Total:						737392.14
Intensive Active Treatment	15 min.	54	521.00	26.21	737392.14	
Meals Total:						49569.52
Meals	per meal	11	182.00	24.76	49569.52	
GRAND TOTAL:						18112570.38
Total Estimated Unduplicated Participants:						2120
Factor D (Divide total by number of participants):						85430.46
Average Length of Stay on the Waiver:						335

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nursing Oversight and Care Management Total:						357053.60
Nursing Oversight and Care Management	15 min.	80	131.00	34.07	357053.60	
Specialized Medical Equipment Total:						26628.80
Specialized Medical Equipment	1 unit	17	10.00	156.64	26628.80	
Specialized Private Duty Nursing Total:						56860.26
Specialized Private Duty Nursing	15 minutes	2	1263.00	22.51	56860.26	
Transportation Total:						269487.96
Transportation	per ride	79	124.00	27.51	269487.96	
GRAND TOTAL:					18112570.38	
Total Estimated Unduplicated Participants:					2120	
Factor D (Divide total by number of participants):					85430.46	
Average Length of Stay on the Waiver:					335	