

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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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.

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

### 1. Request Information (1 of 3)

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- A. The State of Louisiana 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*):  
Coordinated System of Care (CSoC) Severely Emotionally Disturbed (SED) Children's Waiver
- C. Type of Request: new

**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

☐ New to replace waiver

Replacing Waiver Number: \_\_\_\_\_

☐ Migration Waiver - this is an existing approved waiver

Provide the information about the original waiver being migrated

Base Waiver Number: \_\_\_\_\_

Amendment Number \_\_\_\_\_

(if applicable): \_\_\_\_\_

Effective Date: (mm/dd/yy) \_\_\_\_\_

Waiver Number: LA.0889.R00.00

Draft ID: LA.29.00.00

- D. Type of Waiver (*select only one*): \_\_\_\_\_

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

03/01/12

Approved Effective Date: 03/01/12

### 1. Request Information (2 of 3)

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- 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**

Select applicable level of care

☒ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

Psychiatric Care within a general hospital and inpatient psychiatric hospital for individuals under age 21 as provided in 42 CFR 440.160.

**Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

☒ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

N/A

**Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

## 1. Request Information (3 of 3)

- G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

**Not applicable**

☒ **Applicable**

Check the applicable authority or authorities:

**Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix 1**

☒ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Louisiana Behavioral Health Services 1915(b) waiver which is being submitted at the same time as this waiver will operate concurrently with this waiver.

**Specify the §1915(b) authorities under which this program operates (*check each that applies*):**

☒ **§1915(b)(1) (mandated enrollment to managed care)**

**§1915(b)(2) (central broker)**

☒ **§1915(b)(3) (employ cost savings to furnish additional services)**

☒ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

**A program authorized under §1915(i) of the Act.**

**A program authorized under §1915(j) of the Act.**

**A program authorized under §1115 of the Act.**

Specify the program:

**H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

☒ This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**2. Brief Waiver Description**

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods. The HCBS SED waiver is designed as a nursing facility and hospitalization diversion program. The goal of the SED waiver is to divert nursing facility and psychiatric hospitalization placement through the provision of intensive home and community-based supportive services in an effort to maintain children and youth in their home and community.

The Louisiana SED waiver provides to child/youths and their families five services not available to other Medicaid youth. These services are: Independent Living/Skills Building, Short term respite, Youth Support and Training, Parent Support and Training, and Crisis Stabilization.

Child/youths eligible for the waiver are between the ages of birth up to and including age 21.

Both clinical and financial criteria must be met to be eligible for the waiver. The clinical assessment is a multi-step process. A child/youth must have a mental health diagnosis determined by physician or licensed mental health professional (LMHP) and qualifying scores on a standardized assessment tool, the Child and Adolescent Needs and Strengths (CANS) Comprehensive Multisystem Assessment. Financial eligibility is determined by DHH Medicaid eligibility workers.

The waiver is managed by the Operating Agency, Office of Behavioral Health (OBH), which is a division within the single state agency Louisiana Department of Health and Hospitals (DHH). SED waiver services are provided by the Statewide Management Organization (SMO) and by Wraparound Agencies. The OBH contracts with a Prepaid Inpatient Health Plan (PIHP), also known as the SMO, to review and authorize waiver services through the SMO's database and Electronic Health Record system. The OBH has access to the SMO's database and Electronic Health Record system.

The five waiver services can only be delivered by providers in accordance with the concurrent Louisiana 1915(b) waiver who are credentialed, enrolled and paid by the SMO. The providers must meet both state licensing and HCBS provider requirements.

**3. Components of the Waiver Request**

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one):*

**Yes. This waiver provides participant direction opportunities. Appendix E is required.**

☒ **No. This waiver does not provide participant direction opportunities. Appendix E is not required.**

- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

#### 4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

Not Applicable

No

☒ Yes

- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

No

☒ Yes

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

- ☒ **Geographic Limitation.** A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

Individuals in five regions may enroll in the CSoc 1915(c) SED waiver on March 1, 2012.

- Region 2 includes the parishes of East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, and West Feliciana.

- Region 7 includes the parishes of Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, and Winn.

- Region 8 includes the parishes of Bienville, Bossier, Caddo, Claiborne, Desoto, Jackson, Natchitoches, Red River, Sabine, and Webster.

- Region 9 includes the parishes of Caldwell, East Carroll, Franklin, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, and West Carroll.

- Jefferson Parish (Part of Act 1225 Region 1)

- \* Effective upon approval, all of the Act 1225 Region 1 parishes will offer enrollment in the SED 1915 (c) waiver. Parishes added are St. Bernard, Plaquemines and Orleans.

No other firm implementation plans exist for additional phase-in. Waiver and contract amendments will be submitted to CMS when and if additional Regions/Parishes are implemented.

- ☒ **Limited Implementation of Participant-Direction.** A waiver of statewide requirements is requested in order to make *participant-direction of services* as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

*Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

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In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
  2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who 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. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

**H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

**I. Public Input.** Describe how the State secures public input into the development of the waiver:

Nine Town Hall Meetings were held announcing this program from February 17 – March 3, 2011 throughout the State, explaining the waivers, and gathering input. Copies of the presentation for those Town Halls can be found at [www.dchs.louisiana.gov/index.cfm?md=pagebuilder&tmp=home&pid=272](http://www.dchs.louisiana.gov/index.cfm?md=pagebuilder&tmp=home&pid=272)

A press release was issued on March 3, 2011. A newspaper notice in the state's eight major daily newspapers as well as the Louisiana Register was placed on March 11, 2011 notifying the public of the availability of proposed State Plan Amendments including reimbursement changes, proposed 1915(c) and 1915(b) waivers as well as the public meeting on March 28, 2011.

The newspaper notice listed the availability of the documents on the Coordinated System of Care website <http://www.dchs.louisiana.gov/index.cfm?md=pagebuilder&tmp=home&pid=272>

as well as the DHH website. The State begins the rulemaking process during the month of March. That rulemaking process will also include a full public notice process that will be completed prior to implementation. A report to the appropriate Legislative Oversight Committee will be made in accordance with the Administrative Procedures Act. Full Legislative analysis and briefings will be prepared and held as part of the rulemaking process.

Sections 953 and 954 of the Louisiana Administrative Procedure Act (APA) describes the procedures governing the adoption, amendment and repeal of an administrative Rule as well as the filing and taking effect of Rules. The promulgation of an Emergency Rule (ER) or a Notice Of Intent (NOI) is one venue of public notice of a proposed change and is recognized as such by CMS. ERs and NOIs are published in the state's official journal, the Louisiana Register, on the 20th of the month.

The APA requires that a public hearing be conducted between 35 and 40 days following the publication of a NOI in the Register. Interested parties are permitted to give oral testimony or written comments at the hearing regarding the proposed Rule. An oversight report must be submitted to the applicable legislative committee containing a copy of the original or revised NOI (only non-substantive revisions can be made), written comments received and our responses, a roster of attendees and hearing certification. We must wait 30 days after the submission of the oversight report to afford the committee an opportunity to conduct hearings before we can proceed to finalize the Rule.

**J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

**A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:**

**Last Name:**

Owen

**First Name:**

**Title:** Lou Ann  
**Agency:** Deputy Medicaid Director  
**Address:** Department of Health and Hospitals  
**Address 2:** 628 N. 4th Street  
**City:** Baton Rouge  
**State:** Louisiana  
**Zip:** 70821-9030  
**Phone:** (225) 342-9767 **Ext:** TTY  
**Fax:** (225) 342-9508  
**E-mail:** LouAnn.Owen@LA.gov

**B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:**

**Last Name:** Gradney  
**First Name:** Charlene  
**Title:** DHH Program Manager 2  
**Agency:** Office of Behavioral Health  
**Address:** 628 N. 4th Street, Room 472  
**Address 2:**  
**City:** Baton Rouge  
**State:** Louisiana  
**Zip:** 70802-4049  
**Phone:**



(225) 342-9239

Ext:

TTY

Fax:

(225) 342-5066

E-mail:

charlene.gradney@la.gov

## 8. Authorizing Signature

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This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

Timothy White

State Medicaid Director or Designee

Submission Date:

Apr 24, 2013

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**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

Last Name:

Kennedy

First Name:

Ruth

Title:

Medicaid Director

Agency:

BHSF

Address:

628 N 4th Street., 7th Floor

Address 2:

City:

Baton Rouge

State:

Louisiana

Zip:

70802

Phone:

(225) 342-3032

Ext:

TTY

**Fax:**

(225) 342-9508

**E-mail:****Attachment #1:** ruth.kennedy@la.gov**Transition Plan**

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Specify the transition plan for the waiver:

As the SMO is implemented, youth transitioning onto the SED waiver will be enrolled in the new PIHP network which is a non-risk health care delivery system. To ensure a smooth transition, children currently eligible for Medicaid FFS Mental Health Rehabilitation and clinic services and are in one of the regions covered by the SED waiver will be screened to determine if they are eligible for the SED waiver. Any child found to be eligible for the SED waiver will have their current services reviewed and continued as needed through the Child and Family Team Process care planning process described in Appendix D.

Individuals in five regions may enroll in the CSoC 1915(c) SED waiver on March 1, 2012.

- Region 2 includes the parishes of East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, and West Feliciana.
  - Region 7 includes the parishes of Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, and Winn.
  - Region 8 includes the parishes of Bienville, Bossier, Caddo, Claiborne, Desoto, Jackson, Natchitoches, Red River, Sabine, and Webster.
  - Region 9 includes the parishes of Caldwell, East Carroll, Franklin, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, and West Carroll.
  - Jefferson Parish (Part of Act 1225 Region 1)
- \* Effective upon approval, all of the Act 1225 Region 1 parishes will offer enrollment in the SED 1915(c) waiver. Parishes added are St. Bernard, Plaquemines and Orleans.

No other firm implementation plans exist for additional phase-in. Waiver and contract amendments will be submitted to CMS when and if additional Regions/Parishes are implemented.

**Additional Needed Information (Optional)**

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Provide additional needed information for the waiver (optional):

**Appendix A: Waiver Administration and Operation**

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- 1. State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

- ☒ The waiver is operated by the State Medicaid agency.

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

- ☐ Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

**Office of Behavioral Health (OBH) within Department of Health and Hospitals (DHH)**  
(Complete item A-2-a).

**The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

## Appendix A: Waiver Administration and Operation

### 2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:  
The single state Medicaid agency, the Louisiana Department of Health and Hospitals is the umbrella agency for the Medical Assistance Unit - Bureau of Health Services Financing (BHSF) - and the Operating Agency Office of Behavioral Health (OBH).

OBH directly holds the contract with the Statewide Management Organization and is responsible for all day-to-day operation of the CSoc 1915(c) waiver as outlined in the waiver.

The two divisions have an interagency agreement which, among other things,

- Specifies that BHSF is the final authority on compensatory Medicaid costs
- Recognizes the responsibilities imposed upon BHSF as the agency authorized to administer the Medicaid program, and the importance of ensuring that BHSF retains final authority necessary to discharge those responsibilities.
- Requires BHSF approve all new contracts, MOUs, grants or other similar documents that involve the use of Medicaid funds.
- Notes that the agencies will work in collaboration for the effective and efficient operation of Medicaid health care programs, including in the development and implementation of all program policies, and for the purpose of compliance with all required reporting and auditing of Medicaid programs.
- Requires BHSF has final approval of regulations, SPAs and MMIS policies, is responsible for the policy process, and is responsible for the submission of applications/amendments to CMS in order to secure and maintain existing and proposed waivers, with OBH furnishing information, recommendations and participation. (The submission of the waiver application is an operational example of this relationship: Core concepts were developed through an interagency work group that involved program and operations staff from both BHSF and OBH; functional pieces of the waiver were developed by OBH staff; and overview/approval of the submission was provided by BHSF, after review by key administrative and operations staff and approval of both agencies' leadership.)

In addition to leadership-level meetings to address guiding policy and system management issues (both ongoing periodic meetings and as needed issue-specific discussions), BHSF ensures that OBH performs assigned operational and administrative functions as follows:

- a) A monthly meeting is held by BHSF with representatives from OBH to discuss:
  - a. information received from CMS
  - b. proposed policy changes

- c. waiver amendments and changes
- d. data collected through the quality review process
- e. eligibility, numbers of children being served
- f. fiscal projections for the fiscal year, and
- g. any other topics related to the waivers and Medicaid.
- b) All policy changes related to the waivers are approved by BHSF. This process includes a face-to-face meeting with BHSF staff.
- c) Waiver renewals, 372 reports, and requests for waiver amendments must be approved by BHSF.
- d) Correspondence with CMS is copied to BHSF.

The Louisiana Bureau of Health Services Financing, as BHSF, has oversight responsibilities for all Medicaid programs, including the following functions related to HCBS waivers.

- Utilization Management: ongoing reporting related to the SED Waiver Onsite Chart Reviews is conducted during the monthly IMT meetings with BHSF. OBH staff present recent SED Waiver chart review findings and trends to the IMT committee.
- Aggregate analysis reporting is conducted on a quarterly basis during OBH State Quality Committee meetings. Included in this reporting are specific SED Waiver reports. Representatives from BHSF attend and receive materials for each meeting. Data is also presented during the Intergovernmental Monitoring Team (IMT) meetings that include BHSF and OBH. Specifically, BHSF assures that all expenditures are made in compliance with relevant statutory authority, regulatory authority, state plans, policies, program manuals and program guidance. BHSF also assures that services and the delivery of services are made within statutory authority, regulatory authority, state plans, policies program manuals and program guidance.
- Execution of Provider Agreements/Qualified Provider enrollment: OBH provides oversight to the SMO to assure that all enrolled Medicaid providers meet the documented qualifications. In order to enter into a provider agreement with the SMO to provide SED Waiver services, proof of Medicaid qualifications must be present. OBH will examine a statistically valid random sample of all qualified providers of SED Waiver Services to ensure all providers meet the requirements as described in the Waiver Application per performance measures outlined in Appendix C. The results of which will be reported to BHSF through the IMT meetings.
- Establishment of a Statewide Rate Methodology: BHSF provides oversight and assistance with the development and completion of an HCBS statewide rate methodology.
- Rules, Policies, procedures and information development governing the waiver program: BHSF assists in the development governing the waiver program.

For each delegated function, BHSF provides the following oversight.

- Quality assurance and quality improvement activities: BHSF assists in the development of and oversees all waiver assurances and minimum standards of quality. Quality assurance/improvement data are reviewed on a regular basis during the monthly IMT meeting. These data are also presented quarterly at the Governance Team meeting. OBH will ensure BHSF access to trended data for all assurances which BHSF would be able to access at any time. Included in the quality assurance data are LOC evaluations and child/youth service plan assurances. BHSF reserves the right to ask for additional information, follow-up and/or future plans in response to any data reviewed.
- Child/youth waiver enrollment: BHSF monitors waiver enrollment through monthly reports from the SMO to OBH reviewed at IMT meetings.
- Waiver enrollment managed against approved limits: BHSF has full access to the CMS-approved numbers in the waiver and data collected through the SMO which reflects current recipient numbers. If the numbers should be substantially higher or lower, BHSF would ask for an explanation and/or a plan to amend the current request to CMS. This information can also be reported through the IMT meeting.
- Waiver expenditures: BHSF monitors waiver expenditures through monthly updates of the SMO reports to OBH which are reviewed at IMT meetings.

Prior authorization and/or utilization management of waiver services: Prior authorization and utilization management of waiver services is done by the SMO through a system designed and run by the SMO. Payments are made based on the approvals in the system and cannot exceed what has been prior approved by SMO. Should issues arise in how this check and balance system is functioning, it would be OBH's responsibility to work with the SMO to correct the issue.

- b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify

the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

**As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.**

## Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- ☒ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*

Providers of waiver services are required to enroll with Statewide Management Organization (SMO), which will handle all application, enrollment and credentialing. The Louisiana behavioral health services 1915(b) waiver will authorize mandatory enrollment in a non-risk Prepaid Inpatient Health Plan (PIHP) for children and in an at-risk PIHP for adult services. (Note: Adults behavioral health HCBS services are being requested separately under a 1915(i) state plan amendment option.) The OBH with the SMO manages Medicaid behavioral health services, including outpatient services, rehabilitative services, and home and community-based services under the HCBS CSOC SED waiver. The SMO pays covered behavioral health procedure and diagnosis codes to enrolled qualified Medicaid behavioral health providers providing services to Medicaid child/youths.

Local Wraparound Agencies will be the locus of treatment planning for the provision of all SED waiver services. Wraparound Agencies are the care management agencies for the day-to-day operations of the waiver in the parishes they serve. The Wraparound Agencies will contract through the PIHP and are responsible for the treatment planning of 1915(c) waiver programs in their areas under 42 CFR 438.208(c) authority under the PIHP.

The PIHP must assure that the policies and procedures for the waiver are followed. The SMO is responsible for the health, safety and welfare of child/youths receiving services, for assuring integrity and improvement of the provision of services and supports with the Wraparound Agency.

PIHP responsibilities are as follows:

- Report to the OBH and serve as the single point of entry for HCBS evaluations and contact with the Medicaid eligibility staff.
- Provide information to waiver child/youths about their rights and protections.
- Assure family/recipient awareness and choice for all available waiver services and responsibilities, including the right to change providers.
- Resolve issues related to child/youths' health and safety or service delivery that are unresolved by the wraparound facilitator.
- Contract with network service providers and pay claims.
- Maintain service provider list, recruit providers to address unmet needs, provide training and technical assistance to providers contracted to provide services.
- Provide utilization management through prior authorization and review of paid claims data with follow-up as necessary.
- Quality management.
- Grievances and appeals.
- Provide or arrange for 24/7/365 crisis response system.
- Conduct ongoing monitoring of contracted providers based on a standardized monitoring protocol and scheduled based on an approved performance measures in waiver.
- Oversee and provide follow-up of to ensure implementation of plans of correction.

**No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

## Appendix A: Waiver Administration and Operation

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- 4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

☒ **Not applicable**

**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

*Specify the nature of these agencies and complete items A-5 and A-6:*

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Specify the nature of these entities and complete items A-5 and A-6:*

## Appendix A: Waiver Administration and Operation

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- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Office of Behavioral Health (OBH), and the Louisiana Bureau of Health Services Financing (BHFS), are responsible for assessing the performance of the operational and administrative functioning of the SMO.

## Appendix A: Waiver Administration and Operation

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- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

This waiver operates concurrently with the Louisiana Behavioral Health Services 1915(b) Waiver.

Performance expectations and methods of evaluation and oversight by the State, which are summarized below, are delineated in the non-risk contract between OBH and the SMO.

Oversight of the concurrent waivers is performed by an Inter-Departmental Monitoring Team (IMT) with representation from all divisions within the DHH and other agencies participating (DCF, OJJ, and DOE) involved in the operation of the 1915(b)(c) waivers. The IMT meets quarterly with OBH leading the team. At these quarterly meetings, the SMO reports to the IMT on internal quality assurance/improvement activities such as child and provider surveys, performance measures, complaints and grievances and other issues or concerns that affect service delivery. The team provides feedback and assists in implementing corrective action plans as needed. Representatives of the IMT in conjunction with the EQRO also conducts an annual on-site review of SMO operations. The EQRO and state on-site review analyzes the overall SMO operations, including utilization and care management, clinical direction, executive management, claims processing, financial management, information systems and reporting. A

written report of findings is generated and a plan of correction for deficiencies is implemented if needed. Progress with the plan of correction is tracked by the IMT quarterly.

OBH requires quarterly and annual statistical reporting on service utilization and access to care. OBH also requires quarterly complaints and grievance reports and takes corrective action as needed.

BHSF and OBH contracts with an EQRO, as required by federal managed care regulations, to evaluate the SMO's compliance with the quality assurance standards outlined in the non-risk contract. An Independent Assessment is also conducted once during each of the first two-year 1915(b) waiver period and consists of both a desktop review and an on-site visit.

## Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.

*Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

*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: Administrative Authority

*The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.*

#### i. Performance Measures

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**

**Performance Measure: #1 Number and/or percent of aggregated performance measure reports generated by the Operating Agency and reviewed by the State Medicaid Agency that contain discovery, remediation, and system improvement for ongoing compliance of the assurances.**

**Data Source (Select one):**

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

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



Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

**Performance Measure:**

**Performance Measure: #2 Number and/or percent of waiver amendments, renewals, and financial reports approved by the State Medicaid Agency (BHSF) prior to implementation by the Operating Agency (OBH).**

**Data Source (Select one):**

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

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

**Performance Measure:**

Performance Measure: #3 Number and/or percent of waiver concepts and policies requiring MMIS programming approved by the State Medicaid Agency prior to the development of a formal implementation plan by the Operating Agency.

**Data Source (Select one):**

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

	Specify:	
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**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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.

The OBH reports to BHSF monthly through the IMT. OBH reports the results of recent SED waiver chart reviews at the IMT meetings. The OBH also provides updates with regard to waiver quality processes and HCBS issues as they arise.

**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.

The SMO will address and correct problems identified on a case-by-case basis in accordance with its contract with OBH. OBH may require a corrective action plan for the problems identified. OBH monitors the corrective action plan with the assistance of the Inter-Departmental Monitoring Team. The SMO will notify the State immediately of any situation in which the health and safety of a child is jeopardized.

The SMO, in partnership with the OBH, request, approve, and assure implementation of provider corrective action planning (and formal responses) and/or technical assistance to address non-compliance with waiver performance standards as detected through onsite SED chart reviews at each provider. The provider is notified verbally of deficiencies and/or non-compliance in a closing conference after each provider SED review visit. The provider is then notified by the SMO through certified mail of areas of non-compliance and the provider's appeal rights.

Provider data is compiled, trended, reviewed, and disseminated to each provider through the SED review findings letter. The SMO reviews annual data trending which identifies provider-specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests (formal responses), technical assistance and/or follow-up to remediate negative trending are included in annual provider reports where negative trending is evidenced. The SMO reports to OBH and BHSF at the monthly IMT team meeting.

- ii. **Remediation Data Aggregation**

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

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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 Administrative Authority that are currently non-operational.

☒ No

☐ Yes

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

**Appendix B: Participant Access and Eligibility****B-1: Specification of the Waiver Target Group(s)**

- a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<b>Aged or Disabled, or Both - General</b>					
	<input type="checkbox"/>	Aged			
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
	<input type="checkbox"/>	Brain Injury			
	<input type="checkbox"/>	HIV/AIDS			
	<input type="checkbox"/>	Medically Fragile			
	<input type="checkbox"/>	Technology Dependent			
<b>Mental Retardation or Developmental Disability, or Both</b>					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Autism			
		Developmental Disability			
		Mental Retardation			
<input checked="" type="radio"/> Mental Illness					
	<input checked="" type="checkbox"/>	Mental Illness	18	21	
	<input checked="" type="checkbox"/>	Serious Emotional Disturbance	0	17	

b. **Additional Criteria.** The State further specifies its target group(s) as follows:

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

**Not applicable. There is no maximum age limit**

- ☒ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

The child/youth's Plan of Care is reviewed every 90 days, wraparound services are provided on an as needed basis, and there is an annual review of services as long as the child/youth receives SED waiver services. Throughout this process, the child/youth's needs, goals, objectives, resources, and strengths are identified. At any time, the child/youth, their family, or the therapist may identify a need for a change in supportive services for the child/youth. Beginning at age 15, and continuing until the child/youth approaches the age of 22, a continuum of services will be identified by the child/youth and members of the Child and Family Team. OBH staff would link and access those identified services to the child/youth to achieve a successful transition. Coordination between OBH programs for children/youth and OBH adult programs would occur to aid in the transition. When the child/youth is transitioning out of the SED waiver due to maximum age, the OBH evaluates the child/youth for adult community based services and mental health supports. If the child/youth meets the applicable criteria for another waiver then transition to that program would be supported by OBH using the approved methods in the waiver or program that is determined to best meet the child/youth's needs.

The SMO will produce for the Wraparound Agency a monthly report of child/youths that are approaching their 15th through 22nd birthday beginning at age 15. The wraparound agency will facilitate development and implementation of a transition for each individual for each individual as he/she approaches adulthood. The recipient will be referred to appropriate services. The SMO will follow up at least monthly to ensure that transition plans have been completed and implemented successfully.

## Appendix B: Participant Access and Eligibility

### **B-2: Individual Cost Limit (1 of 2)**

a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*) Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

**No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished

to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

**The limit specified by the State is (select one)**

**A level higher than 100% of the institutional average.**

Specify the percentage: .....

**Other**

Specify: .....

- **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

**Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

*Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*

**The cost limit specified by the State is (select one):**

**The following dollar amount:**

Specify dollar amount: .....

**The dollar amount (select one)**

**Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula: .....

**May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

**The following percentage that is less than 100% of the institutional average:**

Specify percent: .....

**Other:**

Specify: .....

## Appendix B: Participant Access and Eligibility

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

- 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:

The Plan of Care (POC) is developed for the child during the application process concurrently with waiver eligibility. The POC must be approved by the SMO to assure his/her health and welfare and ensure that he/she meets the level of care (LOC) to be eligible for waiver participation and that services provided will be within the cost limit. Health and welfare are assured by the combination of Medicaid services, Louisiana SED Waiver services, school services, and other supports received through natural and community resources. Individuals who are not permitted onto the waiver due to the individual cost limit will receive a notice of action and be permitted to Appeal directly to the State Fair Hearing process.

- 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:

The family, wraparound facilitator, or SMO may convene a wraparound meeting in the event of an increased need for service by a waiver child/youth. If the team review determines a need for increased intensity of services, the SMO may approve a time-limited increase (less than 90 days) in the intensity of services. If it is determined at the time of the meeting or at the end of 90 days that the child/youth has an extended need for increased intensity of services, the individuals will be re-assessed by the Wraparound Facilitator and the SMO and transitioned to an inpatient hospital or nursing facilitator if the health and safety of the child/youth cannot be assured.

## 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	1200
Year 2	1200
Year 3	1200
Year 4	

Waiver Year	Unduplicated Number of Participants
	1200
Year 5	1200

- 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)*:

- ☒ The State does not limit the number of participants that it serves at any point in time during a waiver year.

The State limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ☒ Not applicable. The state does not reserve capacity.

The State reserves capacity for the following purpose(s).

## Appendix B: Participant Access and Eligibility

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

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- ☒ The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

- e. **Allocation of Waiver Capacity.**

Select one:

- ☒ Waiver capacity is allocated/managed on a statewide basis.



**Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

- f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

The OBH does not have a waiting list for the SED waiver. A waiting list is not anticipated to be put in place. If a waiting list should occur, entrance parameters would be on a first-come, first serve basis.

## Appendix B: Participant Access and Eligibility

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

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:

- ☒ §1634 State  
☐ SSI Criteria State  
☐ 209(b) State

2. **Miller Trust State.**

Indicate whether the State is a Miller Trust State *(select one)*:

- ☒ No  
☐ Yes

- b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

**Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)**

- ☒ Low income families with children as provided in §1931 of the Act  
☒ SSI recipients  
☐ Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121  
☐ Optional State supplement recipients  
☐ Optional categorically needy aged and/or disabled individuals who have income at:

*Select one:*

- ☐ 100% of the Federal poverty level (FPL)  
☐ % of FPL, which is lower than 100% of FPL.

Specify percentage:

- ☐ Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)

- ☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- ☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- ☐ Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- ☐ Medically needy in 209(b) States (42 CFR §435.330)
- ☒ Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- ☒ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

*Specify:*

- Medicaid Optional targeted low-income children (42 CFR 435.229)
- Qualified pregnant women and children (1902(a)(10)(A)(i)(III), (IV), (VI), and (VII))
- Foster Care and adoption subsidy (42 CFR 435.115(e)(1) and (2); 435.145; 435.222; 435.227)
- Children eligible under the Chaffee Foster Care Independence Act of 1999 1902(a)(10)(A)(ii)(XVII) and 1905 (w)

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*Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

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No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Appendix B-5 is not submitted.*

- ☒ Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

*Select one and complete Appendix B-5.*

All individuals in the special home and community-based waiver group under 42 CFR §435.217

- ☒ Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

*Check each that applies:*

- ☒ A special income level equal to:

*Select one:*

- ☒ 300% of the SSI Federal Benefit Rate (FBR)

A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

- ☐ Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- ☐ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- ☐ Medically needy without spend down in 209(b) States (42 CFR §435.330)
- ☐ Aged and disabled individuals who have income at:

*Select one:*

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

- ☒ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

Medically needy with spend down consisting of the state average monthly cost for private patients in nursing facilities as used for assessing a transfer of asset penalty and other incurred expenses to reduce an individual's income to or below the medically needy income standard.

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 4)

*In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.*

- a. **Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 (*select one*):
- ☒ Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the State elects to (*select one*):

Use spousal post-eligibility rules under §1924 of the Act.  
(Complete Item B-5-b (SSI State) and Item B-5-d)

- ☒ Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)  
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.  
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 4)

#### b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

#### i. Allowance for the needs of the waiver participant (*select one*):

The following standard included under the State plan

Select one:

- SSI standard  
Optional State supplement standard  
Medically needy income standard

**The special income level for institutionalized persons***(select one):***300% of the SSI Federal Benefit Rate (FBR)****A percentage of the FBR, which is less than 300%**

Specify the percentage:

**A dollar amount which is less than 300%.**

Specify dollar amount:

**A percentage of the Federal poverty level**

Specify percentage:

**Other standard included under the State Plan***Specify:***The following dollar amount**

Specify dollar amount: \_\_\_\_\_ If this amount changes, this item will be revised.

**The following formula is used to determine the needs allowance:***Specify:*☒ **Other***Specify:*

The following standard included under the State Plan: The special income level for institutionalized persons (300% of the SSI Federal Benefit Rate (FBR)). The Louisiana CSOC SED children's 1915(c) is a non-risk reimbursement under the rules at 42 CFR 447.362 whereby the health plan, not the State, contracts with and reimburses providers but the health plan is not at risk for these payments. Unlike capitation, the health plan is then reimbursed for all services provided at the amount permitted in FFS, net of patient liability under PETI. The health plan is responsible for the collection of any patient liability under PETI and Louisiana's HIPAA-compliant 834 roster to the health plan will include information on the client including the presence of TPL and PETI. Total payments to the health plan are limited to the non-risk Upper Payment Limit at 42 CFR 447.362. The UPL is calculated net of PETI on HCBS waiver services as well as the collection of TPL when it exists.

**ii. Allowance for the spouse only (select one):****Not Applicable (see instructions)****SSI standard****Optional State supplement standard**☒ **Medically needy income standard****The following dollar amount:**

Specify dollar amount: \_\_\_\_\_ If this amount changes, this item will be revised.

**The amount is determined using the following formula:**

*Specify:*

iii. **Allowance for the family (select one):**

Not Applicable (see instructions)

AFDC need standard

☒ **Medically needy income standard**

The following dollar amount:

Specify dollar amount: \_\_\_\_\_ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

*Specify:*

**Other**

*Specify:*

iv. **Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

**Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

☒ **The State does not establish reasonable limits.**

The State establishes the following reasonable limits

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (3 of 4)

#### c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

**Appendix B: Participant Access and Eligibility****B-5: Post-Eligibility Treatment of Income (4 of 4)****d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

**Appendix B: Participant Access and Eligibility****B-6: Evaluation/Reevaluation of Level of Care**

*As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.*

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

**i. Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

**ii. Frequency of services.** The State requires (select one):

- ☒ The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

*If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

- b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (select one):

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By an entity under contract with the Medicaid agency.

*Specify the entity:*

- ☒ Other  
*Specify:*

By an entity under contract with the operating agency (OBH) – the SMO as described in appendix A-3.

- c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Medical, psychiatric, and psychosocial evaluations to assess medical eligibility for hospital level of care are performed by licensed LMHPs practicing under their scope of practice as permitted under State law and physicians and are forwarded to the SMO for an independent team review. The team authorized by the SMO includes a facilitator from the Wraparound Agency and is reviewed by the SMO Wraparound facilitator. The team authorized by the SMO determines whether the child or youth meets medical eligibility for Hospital or Nursing Facility Level of Care subject to final review by the SMO.

Physician (MD or DO) or Other Licensed mental health practitioner (LMHP) licensed to practice independently

- Medical Psychologists
  - Licensed Psychologists
  - Licensed Clinical Social Workers (LCSWs)
  - Licensed Professional Counselors (LPCs)
  - Licensed Marriage and Family Therapists (LMFTs)
  - Licensed Addiction Counselors (LACs)
  - Advanced Practice Registered Nurses (must be a nurse practitioner specialist in Adult Psychiatric & Mental Health, and Family Psychiatric & Mental Health or a Certified Nurse Specialists in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health, and Child-Adolescent Mental Health and may practice to the extent that services are within the APRN's scope of practice)
- d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Level of Care is determined using the Child and Adolescent Needs and Strengths (CANS) Comprehensive Multisystem Assessment in conjunction with a bio-psychosocial assessment. The CANS is completed initially when the child is referred for services by a mental health professional licensed for independent practice. A re-assessment CANS is then completed at the time of the 30 day service plan review and every 180 days thereafter. The CANS is additionally completed upon disenrollment and any time during enrollment when a significant change in identified risk factors or family strengths is observed or a decision regarding changes in level of care is required.

The CANS Comprehensive Multisystem Assessment is completed based on a face-to-care interview with the child (and parent(s) when possible) and additional supporting information. The CANS generally assesses the child in the following areas: Problem Presentation; Risk Behaviors; Functioning; Care Intensity required to support functioning; Caregiver Capacity; and Strengths. The CANS Comprehensive Multisystem Assessment includes the following domains: Behavioral/Emotional Needs, Child Risk Behaviors, and Life Domain Functioning. The CANS LOC Decision Model recommends the appropriate level of care for treatment services. The recommendation will automatically be calculated based on the behavioral health algorithm for children when a comprehensive CANS or reassessment is completed.

Initial Evaluation: Medical Eligibility requires that the applicant be: (1) A child under 18 years of age with serious emotional disturbance (SED) or a youth aged 18 through 21 years with serious mental illness (SMI); (2) Assessed as requiring hospital or nursing facility level of care, meaning, but for the availability and provision of waiver services, the applicant would fit the medical criteria to be served in a hospital, based on the BHSF nursing facility LOCET criteria or hospital criteria per R.S. 46: 153 (Louisiana Register, Volume 21, No. 6, 6/20/1995). The criteria contain a two-fold definition: severity of need and intensity of service required, both of which must be met. The Team convened by the SMO for the Level of Care will review medical, psychiatric, and psychosocial evaluations, as well as any additional information supplied by the child, family, and wraparound facilitator. In addition to input from the applicant, family, and wraparound facilitator, the SMO may consider information gathered from the Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment.

6-month Re-evaluation: Every 6 months, or more frequently if determined necessary by the SMO, Wraparound Agency, or Child and Family Team due to a significant change in the child/youth's condition or needs, a child/youth's medical need for hospital or Nursing facility level of care shall be reevaluated for continued

participation in the program. A child/youth will be considered to meet the hospital or nursing facility level of care if the child/youth would be in need of a hospital or nursing facility placement but for the continued receipt of waiver services. The reevaluation will also take into account clinical evidence of therapeutic clinical goals that must be met before the individual can transition to a less intensive level of care and clinical evidence of symptom improvement. In addition to input from the child/youth, family, and wraparound facilitator, the SMO may consider information gathered from the Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment.

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

**The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**

- ☒ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The State contracted with John Lyons, creator of the CANS assessment tool, to compare the nursing facility LOCET criteria request for BHSF, which is the institutional precertification LOC criteria, and the hospital certification requirements with the CANS and found that all nursing facility and hospital certification requested information and values are included in the CANS. The CANS has demonstrated strong reliability across users and validity relative to other assessments as well as in predicting treatment and level of care needs. The tool is currently used to support level of care decisions in at least 10 other states and had demonstrated satisfactory utility in those applications. The CANS recommendation for LOC determination will automatically be calculated based on the behavioral health algorithm for children set at the same levels as the Louisiana nursing facility and hospital levels of care when the comprehensive CANS or reassessment is completed. This will result in comparability across eligibility determinations that will be fully comparable to the BHSF nursing facility and Louisiana hospital certification LOC criteria.

- f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

There are two areas of eligibility a child must meet: Clinical (also called Functional) and Financial (also called Medicaid).

**Clinical Evaluation.** A Mental Health Professional Licensed for independent practice is responsible for determining clinical eligibility. Key features of clinical eligibility include:

- Age- A child must be between 0 and through the age of 21 years old.
- Diagnosis- an Axis I mental health diagnosis must be present.
- SED Criteria- All children on the waiver must be identified as SED.
- Inpatient psychiatric hospital criterion criteria: A child must be determined as likely to need an inpatient psychiatric hospital level of care in the absence of waiver services.
- Functional Assessment- All children on the waiver must meet minimum scores for the hospital level of care as determined by the CANS LOC Decision Model.

Note: A wraparound facilitator can assist in obtaining CANS results (e.g. helping the family understand the instrument and questions.) The initial CANS, however, can only be administered and scored by a mental health professional licensed for independent practice.

- Case Management Choice and Release of Information Form – Documentation that the parents or caregivers of the child/youth chose the waiver rather than hospitalization or nursing facility placement

**Financial Eligibility** - If a child is not already eligible for Medicaid, a financial eligibility determination for Medicaid is completed following the LOC determination. A financial redetermination occurs annually.

**Semi-Annual Reevaluation** - The need for HCBS SED Waiver services is re-evaluated at a minimum every 180 days, but also any time the family feels it is appropriate, as needs change, and/or as goals are completed. The format for re-evaluating the level of care is guided by the clinical evaluations of the licensed professional, the progress towards goals and objectives, and the CANS Comprehensive Multisystem Assessment, which is completed every 180 days. The re-evaluation process does differ from the Initial Evaluation. In the initial evaluation, the LMHP conducts standard assessments (CANS), a clinical narrative and clinical indication that the youth is determined to be in need of state psychiatric hospitalization placement in absence of SED Waiver services. The re-evaluation focuses on if



the child/youth continues to be determined to be in need of psychiatric hospitalization or nursing facility level of care and a clinical narrative. This information is captured on the Semi-Annual Review Form.

Notice of Action- When a child is found clinically eligible or ineligible during the initial evaluation or the semi-annual re-evaluation their family will receive a Notice of Action advising them of the status of clinical eligibility.

All clinical eligibility documentation including the initial evaluation, the annual re-evaluation and the notice of action are to be maintained in the child's clinical electronic health record at the Wraparound Facilitation Wraparound Agency and SMO.

All decisions by the team are reviewed by the SMO for consistency with State Guidelines.

- g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

Every three months

☒ Every six months

Every twelve months

Other schedule

*Specify the other schedule:*

- h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

☒ The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

The qualifications are different.

*Specify the qualifications:*

- i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

The SMO contractor's database and electronic medical record maintain ticklers and standard reports on the due dates for timely reevaluations. The database system is able to track the submission of the semi annual POC related to a reevaluation/review date. If a re-evaluation is not submitted in a timely manner, the standard reports will note the outstanding re-evaluation for SMO supervisors and OBH. The reports will be reviewed as a standard part of the IMT and the SMO will be required to follow-up and address any outstanding re-evaluations.

- j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The SMO maintains the completed LOC forms as well as the Wraparound Agency documented in the SMO Care Management Information System.

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

*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: Level of Care Assurance/Sub-assurances

##### i. Sub-Assurances:

*a. Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**

**Performance Measure: #1 Number and/or percent of child/youths who were determined to meet Level of Care requirements prior to receiving waiver services.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Prior Authorization Reports to the OBH from the SMO**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: .....

- b. *Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

#### Performance Measures

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:

**Performance Measure: #2 Number and/or percent of child/youths who receive their annual Level of Care evaluation within twelve months of the previous Level of Care evaluation.**

#### Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval =

<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually	95% <input checked="" type="checkbox"/> Stratified Describe Group: Wraparound agency
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- c. **Sub-assurance:** The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

**Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:**

**Performance Measure: #3 Number and/or percent of child/youths' initial Level of Care determination forms/instruments that were completed as required in the approved waiver.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Wraparound Agencies
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

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

**Performance Measure:**

Performance Measure: #4 Number and/or percent of Level of Care determinations made by a qualified evaluator.

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

**Performance Measure:**

Performance Measure: #5 Number and/or percent of child/youths' semi-annual level of care determinations where level of care criteria was applied correctly.

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input checked="" type="checkbox"/> Other Specify: Semi-annually	

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Semi-annually

- 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.

The SMO will address and correct problems identified on a case-by-case basis in accordance with its contract with the OBH. The OBH may require a corrective action plan for the problems identified. The OBH monitors the corrective action plan with the assistance of the Inter Departmental Monitoring Team. The SMO will notify the State immediately of any situation in which the health and safety of a child is jeopardized. This data is reported to the State Medicaid Agency (BHSF) on a monthly basis at the IMT meeting.

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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 Level of Care that are currently non-operational.

• No

Yes

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

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

**Freedom of Choice.** As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

- a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department of Health and Hospitals, the OBH, SMO, through the Wraparound Agency, informs individuals and/or their authorized representatives of the "feasible alternatives" under the waiver and are given the choice of either institutional or home and community-based services during financial eligibility intake and at the time a waiver offer is made. BHSF Form LTC/CS (Long Term Care/Choice of Services) is used by Medicaid Eligibility for introduction to waiver versus institutional care choice. The OBH currently utilizes the "Case Management Choice and Release of Information Form" to allow the person to state that they understand their choices and the alternatives under the waiver. The information is also reviewed, with the child/youth and/or authorized representative at a "Pre-certification Home Visit" by the Wraparound Agency staff prior to approval of the initial plan of care.

The right of freedom of choice of all waiver service providers is explained to each child/youth by his/her Wraparound Facilitator. Based on the plan of care, as agreed upon each child/youth, the Wraparound Facilitator provides the child/youth and/or his/her legal guardian with a list of all service providers in the child/youth's region for each service the child/youth is to receive. This list is made available for the child/youth to use in his/her selection of service providers and is maintained electronically and updated daily by the SMO. Thus, there is no specific freedom of choice form pertinent to service providers. It is made clear to each child/youth that he/she has choice of selecting any waiver service providers within his/her geographic location from the Freedom of Choice list.

Verification of freedom of choice of providers is indicated by the child/youth or his/her authorized representative through a printed listing of all available providers with the selection circled, signed, and dated by the child/youth or his/her authorized representative. This document is used in lieu of a specific form and is maintained in the child/youth's record at the Wraparound Agency.

- b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The forms are maintained in the records at the SMO and the physical office of the Wraparound Coordinator's office.

## Appendix B: Participant Access and Eligibility

### B-8: Access to Services by Limited English Proficiency Persons

**Access to Services by Limited English Proficient Persons.** Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The SMO makes available, to child/youths with limited English proficiency and their legally responsible representatives, materials that are translated into the prevalent non-English languages of the state. The SMO makes interpreter services available to individuals with limited English proficiency through a contract with a telephone language line and contracts with individual providers in the community for on-site interpretation. The SMO complies with the DHHS Title VI Language Access Policy.

A language service vendor is under contract with The Louisiana Department of Health and Hospitals, (DHH). All Medicaid application forms are published in English, Spanish, and Vietnamese and are available in alternative format upon request.

The SMO is required to make every reasonable effort to overcome any barrier that children may have to receiving services, including any language or other communication barrier. This is achieved by having staff available to communicate with the child in his/her spoken language, and/or access to a phone-based translation service so that someone is readily available to communicate orally with the child in his/her spoken language. The contract will require providers to have staff available to communicate with the child in his/her spoken language, and/or access to a phone-based translation service so that someone is readily available to communicate orally with the child in his/her spoken language.

## Appendix C: Participant Services

### C-1: Summary of Services Covered (1 of 2)

- a. **Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Crisis Stabilization		
Statutory Service	Independent Living/Skills Building		
Other Service	Parent Support and Training		
Other Service	Short-Term Respite		
Other Service	Youth Support and Training		

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

#### Service Type:

Statutory Service

#### Service:

Respite

#### Alternate Service Title (if any):

Crisis Stabilization

#### Service Definition (Scope):

Crisis Stabilization is intended to provide short-term and intensive supportive resources for the youth and his/her family. The intent of this service is to provide an out-of-home crisis stabilization option for the family in order to avoid psychiatric inpatient and institutional treatment of the youth by responding to potential crisis situations. The goal will be to support the youth and family in ways that will address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time. During the time the crisis stabilization is supporting the youth, there is regular contact with the family to prepare for the youth's return and his/her ongoing needs as part of the family. It is expected that the youth, family and crisis stabilization provider are integral members of the youth's individual treatment team.

Transportation is provided between the child/youth's place of residence and other services sites or places in the community and the cost of transportation is included in the rate paid to providers of this services.

FFP is not claimed for the cost of room & board.

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

Duration of services pre-approved for 7 days per episode and up to 30 days per calendar year. Additional days can be authorized with prior approval from SMO or in a SMO-approved Plan of Care.

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
2. Crisis Stabilization shall not be provided simultaneously with Short Term Respite care and does not duplicate any other Medicaid State Plan Service or service otherwise available to recipient at no cost.

**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	Crisis Receiving Center
Agency	Respite Care Services Agency
Agency	Center-Based Respite

## Appendix C: Participant Services

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

**Service Type:** Statutory Service  
**Service Name:** Crisis Stabilization

**Provider Category:**

Agency

**Provider Type:**

Crisis Receiving Center

**Provider Qualifications**

**License (specify):**

RS: 28:2180.12

**Certificate (specify):**

**Other Standard (specify):**

Completion of state approved training according to a curriculum approved by the OBH prior to providing the service.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Statewide Management Organization

**Frequency of Verification:**

Initially, annually, and as necessary

## Appendix C: Participant Services

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

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**Service Type:** Statutory Service  
**Service Name:** Crisis Stabilization

---

**Provider Category:**Agency: **Provider Type:**

Respite Care Services Agency

**Provider Qualifications****License (specify):**

Act 483 of 2005 Respite Care Services Agency

**Certificate (specify):****Other Standard (specify):**

DHH Standards of Participation; LR Vol. 29, No.09, September 20, 2003

The State has specific requirements and minimum criteria for provider enrollment which can be found in the DHH Standards of Participation at the following web-site for the Louisiana Register: <http://www.doa.state.la.us/osr/reg/register.htm>. The citation for the rule is Louisiana Register, volume 29, page 1829 (September 2003).

Completion of state approved training according to a curriculum approved by the OBH prior to providing the service.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Statewide Management Organization

**Frequency of Verification:**

Initially, annually, and as necessary

## Appendix C: Participant Services

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

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**Service Type:** Statutory Service  
**Service Name:** Crisis Stabilization

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**Provider Category:**Agency: **Provider Type:**

Center-Based Respite

**Provider Qualifications****License (specify):**

LAC 48:I.8101-8167

**Certificate (specify):****Other Standard (specify):**

DHH Standards of Participation (LAC 50:XXI.Chapter 1); LR Vol.29, No. 09, September 20, 2003  
 Completion of state approved training according to a curriculum approved by the OBH prior to providing the service.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Statewide Management Organization

**Frequency of Verification:**

Initially, annually, and as necessary

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

☐ Statutory Service

**Service:**

☐ Transition

**Alternate Service Title (if any):**

Independent Living/Skills Building

**Service Definition (Scope):**

Independent Living/Skills Building services are designed to assist children who are or will be transitioning to adulthood with support in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to be successful in the domains of employment, housing, education, and community life and to reside successfully in home and community settings. Independent Living/Skills Building activities are provided in partnership with young children to help the child/youth arrange for the services they need to become employed, access transportation, housing, and continuing education. Services are individualized according to each youth's strengths, interests, skills, goals, and are included on an individualized transition plan (i.e. Waiver Plan of Care). It is expected that Independent Living/ Skills Building activities take place in the community. This service can be utilized to train and cue normal activities of daily living and instrumental activities of daily living.

Housekeeping, homemaking (shopping, child care, and laundry services), or basic services solely for the convenience of a child receiving independent living / skills building are non covered. An example of community settings could encompass: a grocery or clothing store, (teaching the young person how to shop for food, or what type of clothing is appropriate for interviews), unemployment office (assist in seeking jobs, assisting the youth in completing applications for jobs), apartment complexes, (to seek out housing opportunities), Laundromats, (how to wash their clothes), Life safety skills, ability to access emergency services, basic safety practices and evacuation, Physical and mental health care (maintenance, scheduling physician appointments); recognizing when to contact a physician, self administration of medication for physical and mental health conditions, understanding purpose and possible side effects of medication prescribed for conditions; other common prescription and non-prescription drugs and drug uses, use of transportation (accessing public transportation, learning to drive, obtaining insurance), etc. These services may be provided in any other community setting as identified through the Plan of Care process. This is not an all inclusive list.

Transportation provided between the child/youth's place of residence and other services sites or places in the community and the cost of transportation is included in the rate paid to providers of this service. Independent Living /Skills Building does not duplicate any other Medicaid State Plan Service or service otherwise available to recipient at no cost.

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

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
2. Independent Living / Skills Building will not duplicate any other Medicaid State Plan Service or other services otherwise available to recipient at no cost.

**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	Transition Coordination Agency
Individual	Transition Coordinator

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Independent Living/Skills Building****Provider Category:**

Agency

**Provider Type:**

Transition Coordination Agency

**Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

Supervision shall be provided to the Transition Coordinator to provide back up, support, and/ or consultation. A LMHP shall be available at all times to provide back up, support, and/ or consultation.

Employ Transition Coordinators who have a high school diploma or equivalent.

- Must be 21 years of age and have a minimum of 2 years experience working with children with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of work experience and education with one year of education substituting for one year of experience;
- Pass criminal and professional background checks and motor vehicle screens.
- Completion of an approved training in the skills area(s) need by the transitioning youth according to a curriculum approved by the OBH prior to providing the service.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Statewide Management Organization

**Frequency of Verification:**

Upon contracting and annually thereafter

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Independent Living/Skills Building****Provider Category:**

Individual

**Provider Type:**

Transition Coordinator

**Provider Qualifications****License (specify):**

**Certificate (specify):****Other Standard (specify):**

Have a high school diploma or equivalent.

- Must be 21 years of age and have a minimum of 2 years experience working with children with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of work experience and education with one year of education substituting for one year of experience;
- Pass criminal and professional background checks and motor vehicle screens.
- Completion of an approved training in the skills area(s) need by the transitioning youth according to a curriculum approved by the OBH prior to providing the service.
- A LMHP shall be available at all times to provide back up, support, and/ or consultation.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Statewide Management Organization

**Frequency of Verification:**

Upon contracting and annually thereafter

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other (Specify)

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Parent Support and Training

**Service Definition (Scope):**

Parent Support and Training is designed to benefit the Medicaid eligible child/youth experiencing a serious emotional disturbance who without waiver services would require state psychiatric hospitalization or nursing facility institutionalization. This service provides the training and support necessary to support and to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. The specialist shall attend meetings with the family and assist in helping family members to effectively contribute to planning and accessing services including assistance with removing barriers. The specialist assists in describing the program model and providing information as needed to assist the family. Support and training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child/youth (e.g., parenting children with various behavior challenges). This involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the Medicaid eligible child/youth in relation to their mental illness and treatment; development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for the child/youth's symptom/behavior management; assisting the family in understanding various requirements of the waiver process, such as the crisis/safety plan and plan of care process; training on understanding the child's diagnoses; understanding service options offered by service providers; and assisting with understanding policies, procedures and regulations that impact the child with mental illness/addictive disorder concerns while living in the community (e.g., training on system navigation and Medicaid interaction with other child serving systems). The specialist may also conduct follow-up with the families regarding services provided and continuing needs. For the purpose of the CSoC, family is defined as the primary care giving unit and is inclusive of the wide

diversity of primary care giving units in our culture. Family is a biological, adoptive or self-created unit of people residing together consisting of adult(s) and/or child(ren) with adult(s) performing duties of parenthood for the child(ren). Persons within this unit share bonds, culture, practices and a significant relationship. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family. For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, sibling, children, relatives, grandparents, guardians, foster parents or others with significant attachment to the individual. Services may be provided individually or in a group setting.

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

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
2. Parent Support and Training will not duplicate any other Medicaid State Plan Service or other services otherwise available to the recipient at no cost.
3. Services may be provided concurrent with development of the POC to ensure parent support and training and must be intended to address the needs identified in the assessment and to achieve the goals or objectives identified in the child's individualized plan of care.
4. The Family Cultural Support Specialist/Parent Trainer/Group Facilitator provider must be supervised by a person meeting the qualifications for a Family Support Supervisor.
5. The individuals performing the functions of the Family Cultural Support Specialist/Parent Trainer/Group Facilitator may be full-time or part-time (e.g., a Family Cultural Support Specialist may be a part-time employee separate and distinct from a part-time Parent Trainer and/or Group Facilitator).

**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	Family Support Organizations

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Parent Support and Training**

**Provider Category:**

Agency

**Provider Type:**

Family Support Organizations

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**



- Have a high school diploma or equivalent.
- Must be 21 years of age and have a minimum of 2 years experience living or working with a child with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of life/work experience and education with one year of education substituting for one year of experience; (preference is given to Parents or caregivers of children with SED)
- Certification and completion of Parent Support Training according to a curriculum approved by the OBH prior to providing the service pass criminal and professional background check, and motor vehicle screens.
- A LMHP shall be available at all times to provide back up, support, and/or consultation.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Statewide Management Organization

**Frequency of Verification:**

Upon contracting and annually thereafter

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Short-Term Respite

**Service Definition (Scope):**

Short Term Respite Care provides temporary direct care and supervision for the child/youth in the child's home or a community setting that is not facility-based (i.e., not provided overnight in a provider-based facility). The primary purpose is relief to families/caregivers of a child with a serious emotional disturbance or relief of the child. The service is designed to help meet the needs of the primary caregiver as well as the identified child. Respite services help to de-escalate stressful situations and provide a therapeutic outlet for the child. Respite may be either planned or provided on an emergency basis. Normal activities of daily living are considered to be included in the content of the service when providing respite care and cannot be billed separately, these include: support in the home/ after school/or at night, transportation to and from school/medical appointments/ or other community based activities, and/or any combination of the above. The cost of transportation is also included in the rate paid to providers of this service. Short Term Respite Care can be provided in an Individual's home or place of residence or provided in other community settings such as at a relative's home or in a short visit to a community park or recreation center. Respite Services provided by or in an Institution for Mental Disease (IMD) are non-covered. The child must be present when providing Short Term Respite care. Short term Respite care may not be provided simultaneously with Crisis Stabilization Services and does not duplicate any other Medicaid State Plan Service or service otherwise available to recipient at no cost. The Medicaid rate does not include costs for room & board.

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

Short Term Respite Care pre-approved for the duration of 72 hours per episode with a maximum of 300 hours allowed per calendar year. These limitations can be exceeded through prior authorization by the SMO or inclusion in the SMO-approved Plan of Care.

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
2. Short Term Respite Care will not duplicate any other Medicaid State Plan Service or other services otherwise available to recipient at no cost.
3. Medicaid federal financial participation (FFP) will not be claimed for the cost of room and board.

4. Respite care may be provided by a Licensed respite care facility, with the availability of community outings. Community outings would be included on the approved POC and would include activities such as school attendance, or other school activities, or other activities the individual would receive if they were not receiving respite from a center-based respite facility. Such community outings would allow the individual's routine not to be interrupted. Respite is not provided inside a provider facility.
5. The provider must be at least three years older than an individual under the age of 18.

**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	Crisis Receiving Center
Agency	Agency-Personal Care Attendant
Individual	Direct Support Worker
Agency	Center-Based Respite
Agency	Respite Care Services Agency

## Appendix C: Participant Services

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

**Service Type:** Other Service  
**Service Name:** Short-Term Respite

**Provider Category:**

Agency ☒

**Provider Type:**

Crisis Receiving Center

**Provider Qualifications**

**License** (*specify*):

RS: 28:2180.12

**Certificate** (*specify*):

**Other Standard** (*specify*):

Completion of state approved training according to a curriculum approved by the OBH prior to providing the service.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Statewide Management Organization

**Frequency of Verification:**

Initially, annually, and as necessary

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Short-Term Respite**

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**Provider Category:**

Agency [X]

**Provider Type:**

Agency-Personal Care Attendant

**Provider Qualifications****License (specify):**

Personal Care: Louisiana Revised Statutes 40.2006 (E)(2)(m)-(u) & 40.2120.1-2120.7

Supervised Independent Living (Supported Living): Louisiana Revised Statutes 46.26

**Certificate (specify):****Other Standard (specify):**

DHH Standards of Participation; LR Vol. 29, No. 9, September 20, 2003

Completion of state approved training according to a curriculum approved by the OBH prior to providing the service.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Statewide Management Organization

**Frequency of Verification:**

Initially, annually, and as needed

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**Appendix C: Participant Services**

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

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**Service Type: Other Service**

**Service Name: Short-Term Respite**

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**Provider Category:**

Individual [X]

**Provider Type:**

Direct Support Worker

**Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

Direct service workers must enroll as providers directly with the SMO. The following individual qualifications are required for the direct care staff person:

- 1) be at least 18 years of age;
- 2) have a high school diploma, GED, or trade school diploma in the area of human services, or demonstrated competency, or verifiable work experience in providing support to persons with disabilities;
- 3) criminal and professional background checks
- 4) be included on the Direct Service Worker Registry;
- 5) possess a valid social security number;
- 6) provide documentation of current Cardiopulmonary Resuscitation and First Aid Certifications.
- 7) Completion of Respite Training according to the curriculum approved by the OBH prior to providing the service

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Statewide Management Organization  
**Frequency of Verification:**  
 Initially, annually, and as necessary

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Short-Term Respite

**Provider Category:**

Agency

**Provider Type:**

Center-Based Respite

**Provider Qualifications**

**License (specify):**

LAC 48:I.8101-8167

**Certificate (specify):**

**Other Standard (specify):**

DHH Standards of Participation (LAC 50:XXI.Chapter 1); LR Vol.29, No. 09, September 20, 2003  
 Completion of state approved training according to a curriculum approved by the OBH prior to providing the service.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Statewide Management Organization

**Frequency of Verification:**

Initially, annually, and as needed

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Short-Term Respite

**Provider Category:**

Agency

**Provider Type:**

Respite Care Services Agency

**Provider Qualifications**

**License (specify):**

Act 483 of 2005 Respite Care Services Agency

**Certificate (specify):**

**Other Standard (specify):**

DHH Standards of Participation; LR Vol. 29, No.09, September 20, 2003

The State has specific requirements and minimum criteria for provider enrollment which can be found in the DHH Standards of Participation at the following web-site for the Louisiana Register: <http://www.doa.state.la.us/osr/reg/register.htm>. The citation for the rule is Louisiana Register, volume 29, page 1829 (September 2003).

Completion of state approved training according to a curriculum approved by the OBH prior to providing the service.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Statewide Management Organization

**Frequency of Verification:**

Initially, annually, and as needed

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Youth Support and Training

**Service Definition (Scope):**

Youth Support and Training services are child/youth centered support services that provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. The Youth support and training services will have a recovery focus designed to promote skills for coping with and managing psychiatric symptoms while facilitating the utilization of natural resources and the enhancement of community living skills. Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth's individualized POC. The structured, scheduled activities provided by this service emphasize the opportunity for youth to support other children and youth in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Youth Support and Training is a face-to-face intervention with the child/youth present. Services can be provided individually or in a group setting. The majority of Youth Support and Training contacts must occur in community locations where the person lives, works, attends school and/or socializes. This service may include the following components:

- A. Helping the child/youth to develop a network for information and support from others who have been through similar experiences
- B. Assisting the child/youth to regain the ability to make independent choices and take a proactive role in treatment including discussing questions or concerns about medications, diagnoses or treating with their clinician.
- C. Assisting the child/youth to identify and effectively respond to or avoiding identified precursors or triggers that maintain or increase functional impairments.
- D. Assist the child/youth with the ability to address and reduce the following behaviors: reducing reliance on Youth Support and Training over time, rebelliousness behavior, early initiation of anti-social behavior (e.g., early initiation of drug use), attitudes favorable toward drug use (including perceived risks of drug use), antisocial behaviors toward peers, contact with friends who use drugs, gang involvement, and intentions to use drugs

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

Local Education Agencies may not provide this service.

Limit of 750 hours of youth support and training per calendar year. This limit can be exceeded when medically necessary through prior authorization.

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.

2. The Youth Support and Training provider must be supervised by a person meeting the qualifications for a Youth Support and Training Supervisor and a Licensed Mental Health Professional.

**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	Family Support Organizations

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Youth Support and Training

**Provider Category:**

Agency ☒

**Provider Type:**

Family Support Organizations

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

Must be at least 18 years old and have a high school diploma or equivalent. Certification in the State of Louisiana to provide the service, which includes criminal and professional background checks, and completion of a standardized basic training program approved by the OBH. Self-identify as a present or former child recipient of behavioral health services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Statewide Management Organization

**Frequency of Verification:**

Upon contracting and annually thereafter

## Appendix C: Participant Services

### C-1: Summary of Services Covered (2 of 2)

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

**Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

- ☒ **Applicable** - Case management is furnished as a distinct activity to waiver participants.  
*Check each that applies:*
- ☐ As a waiver service defined in Appendix C-3. Do not complete item C-1-c.
  - ☐ As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.
  - ☐ As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.
  - ☒ As an administrative activity. Complete item C-1-c.

- c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Under the 1915(b)/1915(c) concurrent waivers, the SMO conducts all case management functions compliant with managed care treatment planning requirements at 42 CFR 438.208(c) using Wraparound Facilitators employed by State certified Wraparound Agencies.

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

- a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

**No. Criminal history and/or background investigations are not required.**

- ☒ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The Statewide Management Organization (SMO) must complete a Louisiana State check and motor vehicle screen upon the credentialing of the following independent providers of services:

- Transition Coordinator – Individual
- Direct Support Worker

The SMO conducts criminal background checks on independent practitioners as well.

The OBH will ensure that HCBS CSOC waiver agencies and providers meet required certifications through the utilization of an External Quality Review Organization process. In addition, the providers must provide evidence that required standards have been met at the time of renewing their license. This standard is reviewed by State Quality Assurance/ Performance (QA/PI) Staff at the time of their reviews and sooner if a potential problem is identified.

Provider agencies with direct service providers must also conduct criminal background checks and sex offender checks as well as Louisiana State check and motor vehicle screen on all prospective employees including non-licensed personnel who may have direct access to individuals served at the time an offer of employment is made.

- Family Support Organization Agency - Family Cultural Support Specialist/Parent Trainer/Group Facilitator
- Family Support Organization Agency - Peer Support Specialist
- Transition Coordinator Agency – Transition Coordinator
- Agency-Personal Care Attendant
- Agency – Center Based Respite
- Agency – Respite Care Services Agency

Criminal background checks must be conducted on all prospective employees of licensed agencies and providers who may have direct access to individuals served prior to allowing the employee to work directly

with individuals receiving HCBS services. The scope of the history of background checks is mandated by State law and is conducted by the Louisiana State Police or their designee which includes a nationwide level check. SMO licensed contract agencies must comply with this law. This includes direct care positions, administrative positions and other support positions that have contact with individuals served.

The SMO reviews the provider agency criminal record check policy at the time of initial credentialing of the agency and re-verifies agency credentials, including a sample of criminal background checks, at a frequency determined by the SMO, no less than every three years. Annually, the SMO reviews agency personnel practices to ensure that there is documentation of the criminal background check for each employee hired.

- b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

**No. The State does not conduct abuse registry screening.**

- ☒ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The SMO must perform criminal and professional background checks. It must check the State Sex Offender and Child Predator Registry, maintained by the Bureau of Investigation, State Police Office, as well as the Certified Nurse Aide Registry for information on convictions by a CNA for abuse against the elder or infirm.

Licensed agencies who contract with the SMO must conduct criminal and professional background checks of prospective employees for positions who have direct access to individuals receiving services.

Unlicensed agencies that contract with the SMO to provide services are also required to conduct criminal and professional background checks of prospective employees who may provide waiver services to child/youths.

The SMO reviews the provider agency criminal and professional background checks policy at the time of initial credentialing and re-verifies agency credentials, including a sample of criminal and professional background checks screenings, at a frequency determined by the SMO, no less than every three years. The SMO reviews agency personnel practices annually to ensure that necessary screenings have been performed prior to employment.

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

- c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:***

- ☒ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

**Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

## Appendix C: Participant Services

### C-2: General Service Specifications (3 of 3)

- d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified



by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- ☒ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**

**Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.**

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

**The State does not make payment to relatives/legal guardians for furnishing waiver services.**

**The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ☒ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Services may be provided by a member of the participant's family, provided that the participant does not live in the family member's residence and the family member is not the legally responsible relative. Family members that may provide services include parents of an adult child, siblings, grandparents, aunts, uncles, and cousins. The family member must become an employee of the provider agency or contracted with the SMO and must meet the same standards as direct support staff that are not related to the individual. Payment for services rendered are approved by prior and post authorization as outlined in the POC.

**Other policy.**

Specify:

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Louisiana is seeking approval to operate a concurrent 1915 (b)/(c) waiver that waives consumer choice and allows for the selective contracting of behavioral health providers. Behavioral Health Services in the State of Louisiana,

including HCBS waiver services will be provided through a prepaid inpatient health plan. The contracted PIHP will subcontract with any willing qualified provider meeting the provider qualifications as outlined in the 1915(c) waiver. The 1915(b) waiver allows the State to waive freedom of choice. The 1915(b) requires that the PIHP meet accessibility criteria per state guidelines. However, per federal requirements at 42 CFR 438.6, 42 CFR 438.12, 42 CFR 438.206, 42 CFR 438.230, 42 CFR 438.214, and SMM 2087.4, the PIHP must evaluate the prospective provider's ability to perform the activities to be delegated prior to contracting with the entity. The PIHP must have a written agreement with the provider that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the provider's performance is inadequate. The PIHP must monitor the provider's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. The PIHP must identify deficiencies or areas for improvement, the PIHP and provider must take corrective action and terminate the provider if progress is not made to correct the deficiency or area for improvement. The PIHP is required to associate with other providers of mental health services not included in the PIHP network when the needs of children enrolled cannot be met. In all contracts with health care professionals, the PIHP must have written policies and procedures to ensure: selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination. The PIHP must regularly demonstrate to the OBH and the EQRO that its providers are credentialed. The PIHP's provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

*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: Qualified Providers

##### i. Sub-Assurances:

- a. *Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

#### Performance Measures

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:

**Performance Measure: #1 Number and/or percent of Waiver providers providing waiver services initially meeting licensure, training, or certification requirements prior to furnishing waiver services.**

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**SMO credentialing**

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	<input checked="" type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

**Performance Measure:**

**Performance Measure: #2** Number and/or percent of Waiver providers providing waiver services continuously meeting licensure, training, and certification requirements while furnishing waiver services.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**SMO credentialing**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

**Performance Measure:**

**Performance Measure: #3 Number and/or percent of providers providing waiver services that have an active agreement with the SMO.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**The OBH contracts with a SMO to enroll qualified providers and pay claims**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- b. **Sub-Assurance:** *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.*

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**

**Performance Measure:** #4 Number and/or percent of non-licensed/non-certified providers of waiver services that meet training requirements.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Training verification records**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input checked="" type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Training Contractor		Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

- c. **Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**

**Performance Measure: #5 Number and/or percent of provider trainings operated by the OBH.**

Data Source (Select one):

Other

If 'Other' is selected, specify:

Training verification records

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Training Contractor	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other



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

**Performance Measure:**

Performance Measure: #6 Number and/or percent of active providers (by provider type) meeting ongoing training requirements.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Training verification records**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: SMO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: .....	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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.  
When the SMO or the OBH identify a provider that does not meet licensing and/or training requirements, the State SMO will disenroll the provider until requirements are met. This will be documented by reviewing reports from the training contractor and the SMO.

The SMO will address and correct problems identified on a case by case basis and include the information in the report to the OBH and the IMT. The OBH may require a corrective action plan if the problems identified appear to require a change in the SMO processes for making accurate and timely decisions regarding level of care. The OBH monitors the corrective action plan with the assistance of the Inter-Departmental Monitoring Team.

Any provider issues that affect the health and safety of waiver child/youths are reported to OBH immediately.

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: .....	<input checked="" type="checkbox"/> Annually

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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 Qualified Providers that are currently non-operational.

☒ No

Yes

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

## Appendix C: Participant Services

### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

### C-4: Additional Limits on Amount of Waiver Services

- a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

☒ **Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

**Applicable -** The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.  
*Furnish the information specified above.*

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.  
*Furnish the information specified above.*

- ☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.  
*Furnish the information specified above.*

- ☐ **Other Type of Limit.** The State employs another type of limit.  
*Describe the limit and furnish the information specified above.*

## Appendix D: Participant-Centered Planning and Service Delivery

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

**State Participant-Centered Service Plan Title:**  
Plan of Care

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

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

*Specify qualifications:*

- ☐ **Social Worker.**

*Specify qualifications:*

- ☒ **Other**

*Specify the individuals and their qualifications:*

Under the 1915(b)/1915(c) concurrent waivers, the SMO conducts all case management functions compliant with managed care treatment planning requirements at 42 CFR 438.208(c) using Wraparound Facilitators employed by State certified Wraparound Agencies. The wraparound facilitator must be employed by a Wraparound Agency and meet the following qualifications: have at least a BA/BS degree or be equivalently qualified by work experience or a combination of work experience in the human services field and education with one year of experience, complete Wraparound Facilitation/Community Support Training according to a curriculum approved the OBH within 6 months of hire, and pass a Louisiana criminal history background check, and motor vehicle screens.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

## **Appendix D: Participant-Centered Planning and Service Delivery**

### **D-1: Service Plan Development (3 of 8)**

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

a) The family and youth are offered the resources of Parent Support and Training as well as Youth Support and Training Specialists to directly support the family and youth in the service plan development process.

b) The Child and Family Team shall include the child/youth, parents or caregivers of the child/youth, mental health providers, and other individuals invited to participate in the development of the plan of care by the family.

Development of an individualized care plan: Using the information collected through an assessment, the Wraparound Facilitator convenes and facilitates the Child and Family Team, together with the Team develops a person and family-centered, Individual Care Plan that specifies the goals and actions to address the medical, social, educational and other services needed by the eligible individual. The Wraparound Facilitator works directly with the child, the family (or the child's authorized health care decision maker) and others to identify the strengths, needs and goals of the child and the strengths, needs and goals of the family in meeting the child's needs.

The child/youth and parents or caregivers of the child/youth have the primary role of identifying appropriate goals, strengths, needs, and the development of a risk assessment (crisis plan). Input of all members of the Child and Family Team is used to identify the appropriate, frequency and duration of waiver services, and natural supports that are built into the Plan of Care to assist the child/youth in meeting their goals. The wraparound facilitator plays a role in this process by facilitating the Plan of Care development through documentation of the decisions made by the Child and Family Team, facilitating the overall meeting, and assuring that all members of the team have the opportunity to participate. The child/youth and parents or caregivers of the child/youth have the ability to request a meeting of their Child and Family Team at any time should needs or circumstances change.

The child/youth and parents or caregivers of the child/youth are able to designate a qualified individual of their choosing as the wraparound facilitator.

Additionally, Family Support Organizations—Parent Support Specialists and Youth Support and Training Specialists provide the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child. This involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the child in relation to their mental illness and treatment; development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management; assisting the family in understanding various requirements of the waiver process, such as the crisis plan and plan of care process; interpreting choice offered by service providers; and assisting with understanding policies, procedures and regulations that impact the child with mental illness while living in the community. For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, grandparents, or foster parents.

## **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):

The Wraparound Agency staff or wraparound facilitator contacts the child/youth and/or the parent or caregivers of the child/youth before the initial wraparound meeting. During this contact, the wraparound facilitator or Wraparound Agency staff assures the delivery of the SED waiver brochure which describes the waiver services, free choice of providers, and how to report abuse and neglect. Each waiver child/youth is a member of the SMO and is provided a member handbook. In the member handbook, the member's rights and responsibilities are identified.

The wraparound facilitator provides adequate notice of the plan of care development to the Child and Family Team. To ensure the planning process is timely, Wraparound Agencies will comply with the basic service delivery standards as outlined in the SMO and Wraparound Agency contracts. The SMO will conduct an initial CANS brief screening and if a child meets the criteria, the SMO will refer to the independent practitioner for an independent CANS evaluation using the CANS Comprehensive Multisystem Assessment which is then forwarded to the SMO and team to identify the appropriate services provided for the plan of care. Additionally, the SMO will refer to the Wraparound Agency so that the child/youth can select a facilitator who will collect other information. The wraparound facilitator is responsible for writing the plan of care based upon the determinations made by the Child and Family Team. The wraparound facilitator indicates on the plan of care who is responsible for each task. The SMO will also refer to the Family Support Organization so that they can contact the family to help navigate the system. The SMO will authorize the family to obtain services for 30 days to stabilize the family situation while the POC and eligibility are verified. The child will be enrolled in the 1915(c) waiver if meeting the LOC determination and Medicaid financial eligibility. If the child does not meet LOC and financial eligibility, the appropriate non-Medicaid funding source will be billed and the child will not be enrolled in the waiver. See Appendix G for a description of the appeal rights that any non-Medicaid child will be offered.

The wraparound facilitator guides the development of the Plan of Care. The Plan of Care is developed based upon the CANS Comprehensive Multisystem Assessment and identified goals as determined by the Child and Family Team. The child/youth and parents or caregivers of the child/youth have the primary role of identifying appropriate goals, strengths, needs, and the development of a risk assessment (crisis plan). Input of all members of the Child and Family Team is used to identify the appropriate, frequency and duration of waiver services, and natural supports that are built into the Plan of Care to assist the child/youth in meeting their goals. The wraparound facilitator plays a role in this process by facilitating the Plan of Care development through documentation of the decisions made by the Child and Family Team, facilitating the overall meeting, and assuring that all members of the team have the opportunity to participate. The child/youth and parents or caregivers of the child/youth have the ability to request a meeting of their Child and Family Team at any time should needs or circumstances change. The wraparound facilitator assures Plans of Care are entered into the SMO's database and Electronic Health Record.

a) A treatment plan or Plan of Care must be in place within 30 days of intake for any child/youth accessing services through the SMO. If new to the SMO provider system, the child/youth will be receiving services based upon this Plan of Care while the wraparound process is being completed. The waiver-specific Plan of Care is developed by the Child and Family Team lead by the wraparound facilitator. The wraparound meeting is scheduled at the earliest convenience of the child/youth and parents or caregivers of the child/youth. During the wraparound meeting, a Plan of Care is developed that incorporates both formalized and natural supports to address the identified goals of the Plan of Care.

b) A CANS Comprehensive Multisystem Assessment is conducted as a part of the wraparound process. Input into the Strengths and Needs Assessment is given by all members of the Child and Family Team including the child/youth and parents or caregivers of the child/youth. The Strengths and Needs Assessment addresses the following domains: home, community, financial/economic, health, legal, leisure/recreation, vocational/educational,

socialization, and other. Goal development is directly related to the Strengths and Needs Assessment. Goals are established based upon the child/youth's needs and interventions for goals are built upon the child/youth's identified strengths. The Child and Family Team identifies goals and interventions based upon the Strengths and Needs Assessment. Plan of Care goals identified by the child/youth and parents or caregivers of the child/youth the most pertinent or pressing are given preference.

c) The child/youth and their parents or caregivers are informed by the Wraparound Agency of the array of services that may be accessed through the SED waiver during preliminary discussions of treatment. The array of services available to the family includes waiver-specific services and also includes services available in the system of care outside of the SED waiver. Examples of such service would be traditional behavioral health services such as a medication management and individual therapy providing in the home. Non-traditional community-based services such as wraparound facilitation and psychosocial treatment group would also be available. Natural occurring supports outside of the behavioral health system are also utilized to support the family. Formalized services are not incorporated to take the place of existing or identified natural supports.

d) The core values of the Community-Based Services are Strengths-Based, Family-Centered, Culturally Respectful, and Community-Based. These core values are the foundation for the training that is provided to Community-Based Service providers throughout the state. In keeping with these core values, the wraparound process is a participant-driven process where the child/youth and the parents or caregivers of the child/youth direct the membership of their Child and Family Team. Membership is reflective of individuals the family has identified as a source of support, individuals in the community that may be able to provide support in the future through natural supports, and providers of service. All services are coordinated first through the Child and Family Team's development of the Plan of Care. It is the responsibility of the Child and Family Team to develop the Plan of Care.

e) The wraparound facilitator guides that process by facilitating wraparound meetings and ensuring the waiver requirements are met. The wraparound facilitator is responsible for assisting the Child and Family Team in identifying resources for the child/youth and the parents or caregivers of the child/youth. The wraparound facilitator is a part of the development process and a member of the Child and Family Team. The Wraparound Facilitator then takes on the responsibility of assuring that the needed resources are implemented for the child/youth and parents or caregivers of the child/youth. Continuous monitoring of the plan occurs through 90-day and semi-annual reviews of the Plan of Care.

f) The Plan of Care identifies the assigned task and person responsible for implementing the identified support to attain a specific Plan of Care goal. This includes community partners identified by the Child and Family Team to provide natural supports for the family to meet the child/youth's needs. Each Plan of Care has an identified Crisis Plan section which identifies potential crisis, what action steps (strategies) need to be implemented and the person(s) responsible to mitigate the risk.

g) The Plan of Care is updated at a minimum on a semi-annual basis through the wraparound process. However, a wraparound meeting can be convened at any time in which needs or circumstances have changed or the child/youth and parents or caregivers of the child/youth feel it is warranted, or the needs of the child/youth require the Child and Family Team to meet on a more frequent basis to best coordinate care.

The child/youth and parents or caregivers of the child/youth must be involved in the development of the Plan of Care. Participation is documented through the signatures of the child/youth and parents or caregivers of the child/youth on the Plan of Care. In addition, the SMO must operate from one integrated treatment plan. This reinforces the wraparound process and results in the Plan of Care encompassing all services that may be accessed through the SMO.

## **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.

Each Plan of Care is required to contain a crisis plan. Crisis plans are developed in conjunction with the Plan of Care during the wraparound meeting based upon the individualized preferences of the child/youth and parents of caregivers of the child/youth. As with the Plan of Care itself, the child/youth and parents or caregivers of the child/youth may choose to revise the crisis plan at any time they feel it is necessary. Each crisis plan is individualized to the child/youth. A potential crisis (risk) and appropriate interventions (strategies to mitigate risk) are specific to the child/youth and identified by the Child and Family Team. Training provided to wraparound facilitators highlight the need to identify different levels of intervention on a crisis plan, the different stages of crisis, and how a crisis may be defined differently by each family.

The crisis plan includes action steps as a backup plan if the crisis cannot be averted. The action steps are developed through the wraparound process by the Child and Family Team and incorporated in the crisis plan. The action steps may involve contacting natural supports, calling a crisis phone line, or contacting the wraparound facilitator. The SMO is required to provide 24 hours a day/365 days a year crisis response that is readily accessible to child/youths and their parents or caregivers. A required component of the crisis plan is the contact information for those involved at all levels of intervention during the crisis. Families are provided a copy of the crisis plan as an attachment to their Plan of Care in order to have access to the identified information should a crisis occur.

Should a crisis occur or support worker not arrive for a scheduled appointment, individual contact information is included on the crisis plan. The SMO is required to have staff on-site available by 800 phone number 24 hours a day/365 days a year to respond to calls.

Crisis Stabilization and Short-term respite are services which may be included in a Plan of Care if the Child and Family team deems that the youth and family need those services to give relief to the caregiver (short-term respite) or for a short-term facility-based respite (crisis stabilization). Because each child is unique, the Wraparound Facilitation undertaken by the Child and Family Team designs a child specific Plan of Care including a crisis plan and a back-up plan. The backup plan must be an individualized backup plan and include action steps for the individual to follow in the event of an emergency, including the failure of a support worker to appear when scheduled. Should a crisis occur or support worker not arrive for a scheduled appointment, individual contact information is included on the crisis plan. The SMO is required to have staff on-site available by 800 phone number 24 hours a day/365 days a year to respond to calls and may include arranging for designated provider agencies to furnish staff support on an on-call basis as necessary. The Wraparound Facilitator and Child and Family Team must ensure that an effective back-up plan is crafted to meet the unique needs and circumstances of each youth.

The crisis plan and backup plan must include the identification of potential risks to the enrolled youth and the development of strategies to mitigate such risks. Critical risks must be addressed by incorporating strategies into the plan to mitigate whatever risks may be present. The CANS assessment is used to systematically identify potential risks. Strategies to mitigate risk should be designed to respect the needs and preferences of the waiver participant and may include waiver respite services (short-term respite or crisis stabilization) or crisis intervention (State Plan Service). The Wraparound Facilitator must also be available to assist in the event of crises or staff member no shows.

## **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.

Children/youths and their families will have free choice of providers within the SMO and may change providers as often as desired. Once enrolled in the SMO, if a child/youth is already established with a therapist who is not a member of the network, the SMO is required to make every effort to arrange for the child/youth to continue with the same provider if the child/youth so desires. The provider would be requested to meet the same qualifications as other providers in the network. In addition, if a child/youth needs a specialized service that is not available through the network, the SMO will arrange for the service to be provided outside the network if a qualified provider is available. Finally, except in certain situations, child/youths will be given the choice between at least two providers. Exceptions would involve highly specialized services which are usually available through only one agency in the geographic area. This information is provided in the SMO's member handbook which is given to child/youths upon enrollment in the waiver. Member handbooks are also on the SMO website.



## 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):

The Child and Family Team develops the child/youth's Plan of Care using the Strengths and Needs assessment developed by the LMHP and the wraparound process. Once developed, that same information is submitted electronically for prior authorization to the SMO's Care Management team through the electronic health record and other applicable databases. The SMO staff complete the Cost of Care calculation and verify POC cost meets cost of care requirements as part of the POC approval process. Any communications necessary as part of the approval process occur between the WAA and SMO to ensure that the POC is received, reviewed, and processed in a timely manner. The SMO provides Medicaid-reimbursable mental health services (including SED waiver services) under the OBH's oversight. The OBH maintains a MOU with the State Medicaid Agency regarding waiver program management which is inclusive of the service plan. The service plan approval is delegated to the OBH by the Medicaid Agency through the MOU.

The SMO, at the direction of OBH, will annually conduct SED waiver chart reviews at each of the providers. The sample size of SED waiver charts varies from provider, but the sample size from each provider has a 95 percent confidence level with a +/- 5 percent. The following areas of Plan of Care development are evaluated: identifying information, participation in the Plan of Care development, the Strengths and Needs Assessment, goals and objectives, crisis plan, appropriate signatures, and evidence of the wraparound process.

The State Medicaid Agency monitors the waiver through a review of reporting data provided by the OBH that is obtained through the waiver chart reviews. OBH hosts monthly IMT meetings with the Medicaid agency to provide routine oversight for Louisiana's 1915(c) waivers (including the SED waiver). The OBH reports the results of the SED waiver chart reviews conducted at the provider that have been reviewed to date for the current fiscal year.

The IMT meetings with the Medicaid Agency to provide ongoing oversight of the entire array of Medicaid-reimbursable mental health and substance abuse services provided in Louisiana. Bi-weekly meetings occur between administrative staff of the State Medicaid Agency and the OBH. Administrative and system issues related to the SED waiver are addressed in these forums as they arise.

## 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:*

The Plan of Care is reviewed every 90 days with the child/youth and parents or caregivers of the child/youth. The Plan of Care is updated at a minimum on a semi-annual basis through the wraparound process. However, a wraparound meeting can be convened at any time in which needs or circumstances have changed for the child/youth of the child/youth and parents or caregivers of the child/youth feel it is warranted, or the goals of the child/youth have been met.

The wraparound facilitator contacts the team to meet. Through this meeting, the child/youth and the parent or caregivers of the child/youth work with the Child and Family Team to develop a new plan for the child/youth.

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

- ☐ Medicaid agency  
☐ Operating agency  
☐ Case manager  
☒ Other

*Specify:*

Records are maintained at the SMO and the wraparound facilitation Wraparound Agency for at least six years per RS 40:1299.96.

## 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 SMO, at the direction of OBH, monitors the following: child/youth access to waiver services identified in the service plan, child/youth exercising free choice of providers, services meeting child/youth's needs, effectiveness of the backup plan, child/youth's health and welfare, child/youth's access to non-waiver services in services plans including health services, and methods for prompt follow-up and remediation of identified problems.

An IMT meeting with the OBH, the Medicaid Agency, DCFS, OJJ, DOE, and the SMO are held monthly to address and ensure physical health, mental health, substance abuse, and all waiver services are coordinated. The OBH and DCFS are the agencies that operates the reporting center and investigations of child abuse and adult abuse. This coordination of care for all child/youths among all disciplines is a guiding principle for each participating agency.

The OBH utilizes the following processes to ensure the appropriate implementation for the service plan. When SED waiver chart reviews result in less than 100 percent compliance in any area of plan of care development reviewed, the Wraparound Agencies are notified by the SMO and the OBH of the areas of non-compliance. The Wraparound Agencies develop corrective action (formal response). The Wraparound Agencies submit the plan to the SMO and the OBH for approval.

The SMO runs a report monthly to assure one waiver service a month is delivered to the waiver child/youths. The OBH and the Wraparound Agencies have access to the database and are able to run this report to assure all waiver child/youths receive their identified services no less than identified on the plan of care.

The Wraparound Agencies are required to monitor all plans of care every 90 days or sooner with the child/youth and parents or caregivers of the child/youth and a minimum of every 12 months with the full Child and Family Team. The effectiveness of the backup plan will be assessed and changes will be made when needed.

The Wraparound Agencies submit the Plan of Care through the SMO's database and EHR. Communication between the Wraparound Agency and the SMO will occur to ensure that the electronic POC is received, reviewed, and approvals are processed in a timely manner. When the SMO and the OBH conduct onsite Wraparound Agency SED chart reviews, the Plan of Care in the child/youth's clinical record is compared to the electronic submission of the Plan of Care in the database. The SMO and Family Service Organizations are also responsible for discussing the actual delivery of services with the child and family to ensure that services were actually available and provided. Through this process, the SMO and the OBH assure waiver services are available and provided to the child/youth as stated on the Plan of Care. When a Plan of Care in the review process has been identified as having an error, the SMO will contact the Wraparound Agency per phone, email or through the data system where the Plan of Care is rejected or accepted. The error is resolved before an approval of the Plan of Care is granted.

SED Waiver chart reviews and performance improvement monitoring is completed on a quarterly basis by the SMO under the direction of OBH. The SED Waiver chart reviews include reviewing the initial clinical eligibility packet to ensure child/youths meet the SED criteria and the required level of care, reviewing the family choice assurance

document (freedom of choice) to ensure family choice, reviewing the notice of action, which explains the right to appeal, comparison of the Plan of Care to the database to ensure that identified services are being provided, and reviewing the Plan of Care development through the wraparound process.

Problems identified through the quarterly chart reviews are reviewed by the OBH and the SMO to determine Wraparound Agency compliance with the SED waiver.

The SMO's Corporate Compliance Department under the OBH's oversight is responsible for maintaining a fraud and abuse prevention and detection system. This system audits SED waiver providers randomly to ensure integrity of the program. Additionally, this system audits waiver providers based on identified system triggers or upon the recommendation of the OBH. The SMO meets regularly with the OBH to review findings and to implement subsequent corrective action if deemed necessary.

The OBH will utilize the SMO automated information management system to collect information for tracking data such as demographics, services provided, custody status, residential placement, law enforcement contact, academic performance, and school attendance. The SMO is required to collect data for reporting to OBH as necessary to complete quality improvement information.

Child/youths and parents or caregivers of the child/youths are randomly selected annually to participate in the OBH satisfaction surveys. Child/youths and parents or caregivers of the child/youths rate their satisfaction with services provided, access to services, with providers of services, and access to crisis services. Results of the Satisfaction Surveys are reviewed by the OBH to determine the SMO's compliance with contractual outcomes. The SMO is required to share results of the satisfaction surveys with child/youths. The OBH requires the SMO to submit a follow-up plan to correct identified service gaps or barriers.

An individualized Plan of Care is developed in partnership with the child/youth, family and Child and Family Team based upon the child/youth's strengths and identified needs. The Plan would indicate the frequency and duration of services. It is required that the child/youth receive at least one waiver service a month. The OBH closely monitors this requirement in coordination with the SMO. At a minimum, face-to-face contact with the Wraparound Facilitator would occur with the family every 90 days when the service plan is reviewed or when the member's needs would warrant a change to the service plan.

**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:*

The wraparound facilitator is responsible for formalizing the plan of care for the child/youth. The Child and Family Team, consisting of the child/youth, parents or caregivers of the child/youth, mental health providers, and other individuals invited to participate in the development of the plan of care, monitor the implementation of the Plan of Care as well as the health and welfare of the child/youth. The SMO and Family Service Organizations are also responsible for discussing the actual delivery of services with the child and family to ensure that services were actually available and provided. The Plan of Care is reviewed by the wraparound facilitator at least every 90 days or more often if requested by the child/youth or the family of the child/youth, or the therapist, to determine if the service identified are still appropriate for the child/youth.

The SMO and OBH monitors service plan implementation and child/youth health and welfare through the SED waiver chart reviews that are conducted quarterly. The DCFS (which is part of the IMT) is the agency that operates the reporting hotline and investigations of child abuse abuse.

## **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****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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**

**Performance Measure: #1 Number and/or percent of child/youths reviewed who had plans of care that were adequate and appropriate to their needs and goals (including health care needs) as indicated in the assessment(s).**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Wraparound agencies
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**Performance Measure:**

**Performance Measure: #2 Number and/or percent of child/youths reviewed whose plans of care had adequate and appropriate strategies to address their health and safety risks as indicated in the assessment(s).**

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Wraparound agencies
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

**Performance Measure:**

Performance Measure: #3 Number and/or percent of plans of care that address child/youths' goals as indicated in the assessment(s)

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Wraparound agencies
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**

**Performance Measure: #4 Number and/or percent of child/youths' plans of care that include the child/youth's and/or parent's/caregiver's signature as specified in the approved waiver.**

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data	Sampling Approach (check each that applies):
----------------------------	--

collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Wraparound agencies
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

**Performance Measure:**

Performance Measure: #5 Number and/or percent of child/youths' plans of care that were developed by a Child and Family Team.



Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Wraparound agencies
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

**Performance Measure:**

**Performance Measure: #6** The State requires the SMO to report results of performance measures related to the service plan to the OBH and the Inter-Departmental Monitoring Team (IMT) and requires corrective action as appropriate. Corrective action is monitored at minimum quarterly by the OBH and the IMT.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**SMO reports on service plan performance measures**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Semi-annually (Reporting on measures by PIHP)	

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Semi-annually

- 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:

Performance Measure: #7 Number and/or percent of child/youths whose plans of care were updated within 90 days of the last update.

#### Data Source (Select one):

Other

If 'Other' is selected, specify:

SMO 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input checked="" type="checkbox"/> Other Specify: Ongoing	

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

**Performance Measure:**

**Performance Measure: #8 Number and/or percent of child/youths whose plans of care were updated when warranted by changes in the child/youths' needs**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input checked="" type="checkbox"/> <b>Other</b> Specify: SMO	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: SMO	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**

**Performance Measure: #9 Number and/or percent of child/youths who received services in the type, amount, duration, and frequency specified in the plan of care.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Corporate Compliance Reports to the Operating Agency from the SMO**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: RAND sampling methodology recommended by the OIG
	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other	<input type="checkbox"/> Annually

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
Specify: SMO	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**Performance Measure:**

**Performance Measure: #10 Proportion of new waiver child/youths who are receiving services according to their PCP within 45 days of PCP approval**

**Data Source (Select one):**

Other

If 'Other' is selected, specify:

**Person Centered Plan Record Reviews Financial records**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Semi-annually

- 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:

Performance Measure: #11 Number and/or Percent of child/youth records reviewed, completed and signed freedom of choice form that specifies choice was offered between institutional and waiver services.

#### Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%



<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Wraparound agencies
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

**Performance Measure:**

**Performance Measure: #12 Proportion of children/youths reporting their wraparound facilitator helps them to know what waiver services are available**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	

		<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input checked="" type="checkbox"/> <b>Other</b> Specify: SMO	<input type="checkbox"/> <b>Annually</b>	<input checked="" type="checkbox"/> <b>Stratified</b> Describe Group: Wraparound agencies
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: SMO	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

**Performance Measure:**

**Performance Measure: #13 Number and/or Percent of child/youth records reviewed, completed and signed freedom of choice form that specifies choice was offered among waiver services and providers.**

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

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

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: CME
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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.

The performance data is tracked and trended continuously. Any score below a 100% requires the Wraparound Agency to submit to the SMO a corrective action plan (formal response). This data is reported to OBH on a monthly basis at the IMT meeting. Potential remediation could include a formal response from the Wraparound Agency, provider education, a referral for focused review of the Wraparound Agency by the SMO or recoupment of paid claims. If future changes are required of Louisiana's process due to changes in the State requirements, it is anticipated that the OBH will amend the SMO contract to account for timelines, strategies, and responsible parties.

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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)**

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

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**Appendix E: Participant Direction of Services****E-1: Overview (11 of 13)**

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

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**Appendix E: Participant Direction of Services****E-1: Overview (12 of 13)**

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

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**Appendix E: Participant Direction of Services****E-1: Overview (13 of 13)**

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

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

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

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

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

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

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

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

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

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

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

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

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

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## 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 Coordinated System of Care SED Children's waiver operates concurrently with a 1915(b) waiver through an SMO, which is a PIHP. All waiver applicants/child/youths are notified of their right to request a fair hearing by the SMO in accordance with 42 CFR 431 Subpart E and 42 CFR 438 Subpart F. Child/youths are required to access their SMO's internal appeal process before requesting a hearing with the State.

Upon enrollment in the SMO, the SMO sends each enrollee a brochure explaining Medicaid appeal rights. For children/youth and their families with limited literacy, the Wraparound Facilitator verbally explains their appeal rights during the initial home visit. In addition, per 42 CFR 438.406(a)(1), the SMO will be required to give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. All individuals enrolled in the CSoc will be able to access a family cultural support specialist who can assist the family in addition to the requirements of the SMO, wraparound facilitator and advocacy organizations. When applicants/children/youths are denied participation in the waiver or specific waiver services are denied, terminated, suspended or reduced, the SMO sends a written notice to the individual explaining the reason for the adverse action, instructions on how to access a fair hearing, the time frame for making the request, information on continuation of services during the appeal process (if applicable) and contact information for questions and concerns. The notice also contains information on the state level hearing processes and toll free numbers for the Medicaid agency and for requesting free legal assistance. Notices of termination, suspension or reduction are mailed to the child/youth a minimum of 10 days before the service is actually reduced, terminated or suspended.

As stated above, applicants/child/youths must avail themselves of the appeal process offered by the SMO before accessing the state fair hearing process. This requirement can be found in the concurrent 1915(b) waiver application, subsection 3a of section E, "Grievance System". If the applicant/child/youth requests a hearing, the SMO gathers information on the case and schedules the appeal with an independent reviewer who had no prior involvement in making the adverse decision. The SMO sends a written notice of the reconsideration decision to the individual, along with detailed instructions on requesting a State Fair hearing with the State. Applicants/child/youths may then request an informal appeal with the Louisiana DHH check process and/or a formal appeal with the Louisiana Division of Administrative Law (DAL) (from <http://www.adminlaw.state.la.us/>)

When the suspension, reduction or termination of service is appealed, child/youths may continue to receive services up through the final decision by the State Fair Hearing as long as they meet the appeal deadlines, the original period covered by the authorization has not expired and the child/youth requests continuation of the service.

BHSF eligibility staff utilize 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 Medicaid financing of 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 child/youth does not return this form, it does not prohibit his right to appeal and receive a fair hearing.

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.

Copies of all notices and documentation of appeal decisions are maintained by the SMO. The Administrative Law Judge in the Division of Administrative Law maintains records on the State Fair Hearings and records on the formal hearing.

## 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 SMO has an internal dispute resolution system as required by 42 CFR 438 Subpart F. The internal system encompasses both an appeal process, as described in Appendix F-1, for addressing an "action" and a grievance process for addressing grievances (complaints). "Actions" include the denial or limited authorization of a requested service, reduction, suspension or termination of a previously authorized service, denial of payment for a service, failure to provide services in a timely manner as specified in the risk contract and failure to take action within the timeframes specified in the contract for resolving grievances and appeals.

## 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 SMO is responsible for receiving, reporting, and responding to grievances received for child/youths enrolled in the PIHP, including those supported through the SED waiver. The OBH and Bureau of Health Services Financing (BHSF) will oversee through the IMT meeting process. Grievances are defined as any expression of dissatisfaction other than actions per 42 CFR 438 Subpart F.

- 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 OBH requires the SMO to report to the OBH all grievances under 42 CFR 438 Subpart F made to the SMO not less than quarterly. The submission of the SMO grievance and appeal report is included in the contract between the SMO and the OBH.

A summary copy of the SMO's quarterly grievance and appeal report without personal information is shared with the IMT (which BHSF sits on) in order to develop strategies for system improvement.

Information is recorded on the customer service form and recorded in the SMO grievance and appeal database for analysis. Action taken by the SMO is recorded to include a summary of all issues, investigations and actions taken



and the final disposition resolution. Guidelines define the resolution for types of grievances that may be made. The total number of calendar and working days from receipt to completion are also recorded.

The SMO must accept and dispose of all grievances consistent with the policies and procedures and timelines in 42 CFR 438 Subpart F and approved by CMS in the PIHP contract. The PIHP must dispose of each grievance and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes not to exceed 90 days from the day the PIHP receives the grievance.

## 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).

The SMO is responsible for reporting critical events and incidents to the OBH per its contract, which is consistent with state law (e.g., the Louisiana Children's Code, Title 6, Article 612) and the State's Quality Improvement Strategy submitted to CMS as part of the 1915(b) waiver. The Louisiana Children's Code, Title 6, Article 612, mandates the responsibility for investigating reports of child abuse and/or neglect to the Department of Children and Family Services (DCFS), specifically the Child Protection Investigation (CPI) Program. DCFS has jurisdiction in any setting when the alleged victim is <18 years of age and the alleged perpetrator is considered a caregiver (family or paid). Such incidents shall be reported to the local DCFS office. They investigate, protect, and monitor. This jurisdiction is in addition to that of any appropriate licensing regulatory agency.

For youth 18-21, the Louisiana Revised Statutes 14:403.2 outlines definitions and reporting responsibilities. The Bureau of Adult Protective Services is designated by the Louisiana Department of Health and Hospitals as the agency responsible for carrying out the mandate of Louisiana Revised Statute 14:403.2 with regard to disabled adults ages 18-59 and emancipated minors who live in unlicensed and non-regulated settings and for managing the Adult Protective Services programs in DHH administered facilities.

The DHH Adult Protective Services (APS) serves adults ages 18-59 and emancipated minors who have a mental or physical disability that substantially limits their ability to provide for their own care or protection and who live in the community either independently in their own home or with the help of others or in any other place that is not licensed by a governmental regulatory agency.

APS is responsible for investigating and arranging for services to protect disabled adults at risk of abuse, neglect, exploitation, or extortion. APS clients may include people who are mentally retarded, mentally ill, or have substance abuse problems, and those with medical problems or physical disabilities.

Types of Critical Events:

- Abuse (child/youth): Any one of the following acts which seriously endanger the physical, mental, or emotional health and safety of the child:

- The infliction, attempted infliction, or, as a result of inadequate supervision
- The allowance of the infliction or attempted infliction of physical or mental injury upon the child by a parent or any other person.

- The exploitation or overwork of a child by a parent or any other person.
  - The involvement of the child in any sexual act with a parent or any other person, or
  - The aiding or toleration by the parent or the caretaker of the child's sexual involvement with any other person or of the child's involvement in pornographic displays, or any other involvement of a child in sexual activity constituting a crime under the laws of this state. (Children's Code Article 603)
  - Abuse (adult): The infliction of physical or mental injury on an adult by other parties, including, but not limited to, such means as sexual abuse, exploitation, or extortion of funds, or other things of value, to such an extent that his health, self-determination, or emotional well-being is endangered. (Louisiana Revised Statutes 14:403.2).
  - Exploitation (adult): The illegal or improper use or management of an aged person's or disabled adult's funds, assets or property, or the use of the person's or disabled adult's power of attorney or guardianship for one's own profit or advantage. (Louisiana Revised Statutes 14:403.2).
  - Extortion (adult): The acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority. (Louisiana Revised Statutes 14:403.2).
  - Neglect (child/youth): The refusal or unreasonable failure of a parent or caretaker to supply the child with necessary food, clothing, shelter, care, treatment, or counseling for any injury, illness, or condition of the child, as a result of which the child's physical, mental, or emotional health and safety is substantially threatened or impaired. This includes prenatal illegal drug exposure caused by a parent, resulting in the newborn being affected by the drug exposure or withdrawal symptoms. (Children's Code Article 603)
  - Neglect (adult): The failure, by a care giver responsible for an adult's care or by other parties to provide the proper or necessary support or medical, surgical, or any other care necessary for his well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused. (Louisiana Revised Statutes. 14:403.2).
- Individuals/entities required to report (Child)

**Mandatory reporters:** Professionals who may work with children in the course of their professional duties and consequently are required to report all suspected cases of child abuse and neglect. Of the groups of mandated reporters defined in Children's Code Article 603, one group, "Mental Health/Social Service Practitioner," includes all DCFS Child Protection Investigation Workers, Family Services Workers, and other agency social work staff in DCFS. (Children's Code Article 603). Mandatory reporters include any of the following individuals performing their occupational duties:

- (a) "Health practitioner"
- (b) "Mental health/social service practitioner".
- (c) "Member of the clergy".
- (d) "Teaching or child care provider".
- (e) Police officers or law enforcement officials.
- (f) "Commercial film and photographic print processor".
- (g) Mediators appointed pursuant to Chapter 6 of Title IV.
- (h) A parenting coordinator appointed pursuant to R.S. 9:358.1 et seq.
- (i) A court-appointed special advocates (CASA) volunteer under the supervision of a CASA program appointed pursuant to Chapter 4 of Title IV.

**Permitted Reporters (Children's Code Article 609)** – A person who has cause to believe that a child's physical or mental health or welfare is endangered as a result of abuse or neglect, and consequently may report the suspected case of abuse or neglect in accordance with Article 610.

#### **Mandatory Reporting (child/youth)**

In accordance with Louisiana Revised Statutes 40:2009.13 B reporting criteria, "any person who has knowledge that a state law, minimum standard, rule, regulation, plan of correction promulgated by the department, or any federal certification rule pertaining to a health care provider has been violated, or who otherwise has knowledge that a youth has not been receiving care and treatment to which he is entitled under state or federal laws, may submit a report regarding such matter to the department."

"Any person having cause to believe that an adult's physical or mental health or welfare has been or may be further adversely affected by abuse, neglect, exploitation or extortion shall report to the adult protection agency or to law enforcement." (R.S 14.403.2 C and D)

Louisiana law mandates reporting of abuse and provides that persons who report in good faith have immunity from liability (unless they are themselves involved in the abuse). (Children's Code Article 611)

Any employee of DHH or an affiliate who has knowledge of possible abuse of a client, or who receives a complaint

of abuse from a client or any other person, shall report in accordance with the provisions of this policy, applicable law, and the facility or program office's internal policy and procedures. If the person making the complaint is not an employee, e.g. a client, family member, visitor, etc., DHH staff shall assist the person in making a report, if necessary.

The timelines for reporting are: The provider must report all critical incidents immediately to the SMO. The provider must immediately forward a copy of the completed Critical Incident report to the SMO within 2 hours of the incident occurrence or discovery. The provider may fax or hand deliver the completed critical incident report to the SMO. The SMO enters the critical incident information into the tracking system and forwards to OBH within two hours of the incident.

- 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.

At the time of entry into the SMO, the SMO gives the child/youth and family a member handbook that outlines their rights, protections and the advocacy agencies who can educate and assist in the event of a concern. The wraparound facilitator discusses the rights and protections with the child/youth/legally responsible person as a component of the admissions process to the SED waiver. Opportunities for information training occur during routine monitoring.

Providers within the SMO network are required to inform the child/youth of rights and protections through individual agency procedure.

The SMO operate toll-free care lines where child/youth can receive additional information or assistance, if needed. This line has the capacity to assist child/youth that are primarily Spanish speaking and/or hearing impaired. Child Protection services are available day and night by calling the Child Protection hotline or the local parish Child Welfare office at the appropriate Child Protection phone number provided on the DCFS Website.

Each direct service agency provider is required in its contract with the SMO to have a written orientation program for child/youth being admitted to their programs that include child/youth rights and responsibilities, and grievance and appeal procedures that contain information on abuse and neglect. The SMO will ensure that individual providers enrolled through the 1915(c) waiver are oriented on SMO child/youth rights and responsibilities, and grievance and appeal procedures that contain information on abuse and neglect.

The Abuse and Neglect policy shall be thoroughly and annually explained to all employees and subcontractors of the SMO as follows:

1. All new employees and subcontractors of the SMO and affiliates who have direct contact with clients and/or who work in direct care facilities/programs shall be trained on all aspects of the policy. An acknowledgment of receiving these instructions shall be certified by the employee/subcontractor and maintained on file at the facility.
2. As soon as possible, but within 60 days after the signature of the contract/subcontract, the SMO shall ensure that facility or provider meets the criteria established in this policy, and that staff who have contact with clients and/or who work in direct care facilities have received instruction on the content of the policy. Acknowledgment of the full training shall be certified and maintained on file with the facility/provider.
3. The SMO shall have a continuing responsibility to ensure that appropriate staff/providers are currently informed of rules governing client abuse and neglect, and shall insure that each staff member receives training in the content of this policy not less than once each calendar year and more frequently if needed. Such training shall be documented and maintained on file at the facility.

A record shall be maintained by the SMO for each employee/provider receiving orientation, annual training, or any other training required by this policy. This record shall, at a minimum, include the date that the training was provided, the name and classification of the individual conducting the training, the course title, and the number of hours of instruction received.

- 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.

The SMO is responsible for reviewing and reporting all critical events and incidents per the policy and procedure approved by the OBH. Per the QIS, the SMO also must include a Summary of critical incident reports and crisis plans in the annual report to the OBH for discussion at the IMT meeting reviewing the annual report to assist with the trending and tracking of critical events and incidents at the system level.

When the OBH employee receives a report of a critical event or incident, the employee must follow Adult Protective Services regulations (LA RS 14:403.2) for youth over age 18, Children's code (Article 603) and Licensing standards (LA R.S. 40.2009.20). Any employee of DHH or an affiliate who has knowledge of possible abuse shall do the following, as per OMH Policy 0022005:

- Immediately, if at all possible, but in no case later than one hour after knowledge or suspicion, make a verbal report to the facility/program manager. The facility/program manager may designate others to receive reports in the facility/program's internal policy and procedures. A follow-up written incident report shall be submitted to the facility/program manager or designee as soon as possible, but no later than two hours after the verbal report. If an allegation is against a facility/program manager, the report shall be made to the appropriate program office Assistant Secretary or designee or in the case of the Office of the Secretary to the DHH Deputy Secretary, who will be responsible for carrying out the responsibilities of the facility/program manager outlined in this policy.
- Immediately take appropriate measures to protect the safety and well-being of the client(s) involved. This may include such actions as removing the client(s) from danger, seeking medical attention, or notifying external agencies as outlined below.
- Preserve and protect any evidence related to the allegation in accordance with internal policy and procedure and/or instructions from the facility/program manager or designee and/or from an investigator.
- Policy 0022005 requires that the investigation is conducted and within 12 days the Regional Manager makes a determination.
- Policy 0022005 also required that the complainant is advised of his/her right to appeal the findings/determination to the BPS within 15 calendar dates from the date of notification.

All incidents of possible abuse involving DHH clients as alleged victims and/or DHH affiliate staff as the accused shall be reported immediately to the OBH as set forth in policy # 0102009 and APS procedures. APS may develop specific reporting procedures for individual facilities/programs within DHH.

In addition, State and Federal laws and regulations mandate reporting to the following agencies, based upon the age of the alleged victim, setting, and identity of the alleged abuser. These laws place the burden to report on the individual having knowledge or suspicion of the abuse. It is the responsibility of the facility/program manager to ensure that the appropriate external agencies listed below are notified in a timely manner.

1. The local Child Welfare Office for all allegations involving persons under 18 years of age, regardless of setting, where the accused is a formal or informal caregiver. Allegations of child abuse where the abuser is not a caregiver should be reported to local law enforcement. Reports should be made immediately or as soon as possible after knowledge. Dual reporting to both the local Child Welfare office of DCFS and the local or state law enforcement agency is permitted (Children's Code (Article 610)).
2. The Health Standards Section of the DHH Bureau of Health Services Financing and Adult Protective Services for allegations involving persons who are receiving care in a facility licensed by that Section. This would include: persons residing in a licensed ICF-MR, a licensed nursing home, a licensed hospital, and other licensed health facility as defined in LA RS 40.2009.13. Reports should be made immediately or as soon as possible, but in no case later than 24 hours after knowledge.
3. Adult Protective Services (APS) for all allegations involving persons age 18-59, or emancipated minors, who are mentally, physically, or developmentally disabled when the person resides in a non-licensed setting or when a person residing in a licensed setting is allegedly abused by an accused who is not a staff member of the licensed facility. Reports should be made immediately or as soon as possible after knowledge.
4. The Department of Children and Family Services, Bureau of Licensing for all allegations where the accused is a staff person of a provider licensed by that agency. Reports should be made immediately or as soon as possible after knowledge.

For investigations, all employees of the Department of Health and Hospitals (DHH) and affiliates including the SMO and its providers are required to cooperate in any investigation of abuse. The agencies identified above as receiving external reports also have statutory or regulatory responsibility for investigating those reports and taking protective and/or regulatory action. Those agencies which are part of DHH shall carry out these functions as authorized by statute or regulation and according to their internal policies and procedures. In addition to the investigations already mentioned, allegations of abuse involving DHH clients where the accused is an employee of DHH or an affiliate will

be investigated by the Bureau of Adult Protective Services. DHH offices which operate 24-hour facilities and programs associated with 24-hour facilities shall conduct investigative reviews and initiate appropriate corrective action for all reported allegations of abuse. Abuse and neglect reporting requirements for respite and crisis stabilization providers licensed under DHH are listed in RS 14:403.2 C & D and RS 40, 2009.13B. Should any allegations arise involving DHH clients which do not clearly fall under the jurisdiction of any agency identified above, the allegation may be investigated by the Bureau of Adult Protective Service.

- 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.

The SMO reports all critical incidents and events to the OBH as set forth in policy # 0102009 and the IMT. A multi-agency Memorandum of Understanding delineates the responsibility for oversight of the reporting and response to critical incidents or events that affect waiver child/youth. DCFS has the responsibility for investigating those critical incidents referred to them involving abuse, neglect, misappropriation, extortion and exploitation. Upon completion of the investigation, the OBH are forwarded copies of their findings. The SMO provides aggregate data and produces reports for review for trends and pattern on a quarterly basis at the IMT Quarterly Meeting.

The reports are reviewed internally within the OBH and provided to the Bureau of Health Service Financing as well as shared with the IMT.

The OBH will be responsible for completing the following actions:

- Each day, the OBH will review all new incoming critical incident reports, determine the report priority level (i.e., urgent or non-urgent), and assign the report to staff.
- Immediately, or within 2 hours, notify verbally and in writing (via e-mail) the OBH when critical incidents involve the death or arrest of a child/youth; or when critical incidents of the abuse/neglect of a child/youth results in the involvement of Law Enforcement.

NOTE: The notification information should include, but is not limited to the following:

- Child/youth's full name,
- Cause of death, if known, including pre-and post-death diagnoses, and
- Previous reports concerning the child/youth's care, safety, and well-being; if arrested, the reason for the child/youth's arrest; and the specifics of the incident (i.e., report specifics of who, what, when, where, how).
- Alert staff members of urgent cases (within one business day of receipt of the critical incident) and assure that regional staff takes appropriate action in response to the critical incident.
- Review and approve extension requests made by staff; NOTE: extensions shall not be granted for more than fifteen days at a time.
- Assure that all mandatory fields are entered into the on-line critical event reporting system.
- Track 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; and
- Close cases after all needed follow-up has occurred and all necessary data has been entered into on-line critical event reporting system.

The OBH will be responsible for completing the following actions:

- Continue to follow-up with the SMO, provide technical assistance as necessary, and request additional information in writing until closure of the critical incident;
- Make timely referrals to other agencies as necessary;
- Assure that the SMO enters all necessary information into the OBH-approved on-line reporting data system.
- Assure that activities occur within required timelines, including closure of the incident within thirty (30) days, unless an extension has been granted;
- Submit requests for extension to the OBH for review and approval; and
- Assure that the Child/youth Summary is completed for all cases.

The OBH State Office will be responsible for completing the following actions:

Upon receipt of e-mail or verbal notification involving the death of a child/youth, the arrest of a child/youth, or of the abuse or neglect of a child/youth involving law enforcement, immediately, but not more than two (2) hours, notify in writing, sending via e-mail to all the following:

- OBH Assistant Secretary;
  - OBH Deputy Assistant Secretary;
  - OBH Medical Director
  - DHH Bureau of Media & Communications;
  - OBH Quality Management Staff; and
  - DHH Deputy Chief of Staff.
  - Medicaid Director
- Provide technical assistance to the SMO, OBH and Medicaid units as needed;
  - Identify statewide needs for training regarding the following:
    - Responding to critical incidents,
    - Adhering to the critical incident reporting and tracking policy # 0102009,
    - Entering critical incident data into the OBH-approved data system,
    - Tracking critical incidents and using data for remediation and/or quality enhancement; and/or
    - Other related topics.
  - A sample of critical incidents to review for adherence to policy, including a review to determine if all necessary actions were taken to address/resolve critical incidents is selected; This process is the responsibility of the OBH. The review will include a sample large enough to meet confidence level at 95% plus or minus 5%, with a minimum frequency of annually.
  - Identify necessary remediation to be taken by the Provider, the SMO, and the OBH staff;
  - Aggregate critical incident data and analyze the data to identify trends and patterns;
  - Review reports of the trends and patterns to identify potential quality enhancement goals; and
  - Utilize critical incident data to determine the effectiveness of the OBH quality enhancement strategies.

#### Quality Management Responsibilities:

The OBH will utilize the information and data collected on critical incidents for quality management purposes, including but not limited to the following:

- Development and review of reports to assure that follow-up and case closure of critical incidents occur according to this policy on an on-going basis for individual cases and quality review of aggregate data;
  - Quarterly analysis of data to identify trends and patterns for effective program management that ensures the safety and well-being of people receiving the OBH supports and services and ensures that people receive quality of supports and services from the OBH;
  - Annual analysis of data to determine the effectiveness of quality enhancement goals and activities; and
- Identification of child/youths who experience frequent critical incidents and will need strategies to mitigate risk included in their Plan of Care on an on-going basis by support coordination agencies as they perform their quarterly plan of care reviews.

## Appendix G: Participant Safeguards

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

#### a. Use of Restraints or Seclusion. *(Select one):*

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

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

- ☒ **The use of restraints or seclusion 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 or Seclusion.** 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 or 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).

Licensed 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 which is the application of body pressure to an individual for the purpose of restricting or suppressing the person's movement.

Protective holds are only to be used in an emergency to prevent a person from causing harm to self or others and after other, less restrictive interventions/strategies have failed. Protective holds may only be implemented by trained staff and of short duration. [Louisiana Revised Statutes 40.2006(E)(2) & 40.2120.11-40.2120.16 which cover the broad range of agencies, programs, and facilities who are subject to the Statutes].

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 are utilized.

Direct care staff are required to have initial and annual training in the management of aggressive behavior, including 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 write a Critical Incident Report, and follow appropriate reporting procedures.

The Wraparound Facilitator will contact the participant and his/her legal representatives within 24 hours of receiving the incident report involving a protective hold. Changes to the service plan or living situation will be considered to support the person's safety and well-being. Follow-up visits in response to the Critical Incident Reports and complaints 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.

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

Unauthorized, over use or inappropriate use of protective hold is detected through the annual SMO monitoring approved by OBH. The SMO and OBH will ensure that all applicable state requirements have been followed regarding restraints as part of the Critical Incident report review process. The OBH provides the Bureau of Health Services Financing with aggregate data and reports which are inclusive of any reported restrictive intervention use. 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 2)

#### 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 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.

The State's contract with the SMO includes safeguards regarding time outs which are only permitted in 1915(c) facilities providing crisis stabilization. The SMO is responsible for reporting use of time outs to the OBH per its contract consistent with state law.

- Time-Out-a strategy used to teach individuals to calm themselves, during which a child is not given the opportunity to receive positive reinforcement and/or participate in the current routine or activity until he/she is less agitated.

Additionally, the Children's Health Act of 2000, 42 U.S.C. §290jj, uses the following definition for time out: a behavior management technique that is part of an approved treatment program and may involve the separation of the resident from the group, in a non-locked setting, for the purpose of calming. Time out is not seclusion.

Time outs shall only be used to prevent a patient from physically injuring himself or others. Time outs may not be used to punish or discipline a patient or used as a convenience to the staff of the treatment facility.

Safeguards regarding time outs:

Time out is to be used for behavior shaping techniques. Such confinement may only be used as part of a written treatment plan and may be used only according to the following standards and procedures:

- Placement alone in a room or other area shall be imposed only when less restrictive measures are inadequate.
- Placement alone in a room or other area shall only be ordered by a qualified professional trained in behavior-shaping techniques and authorized in accordance with the written policies and procedures of the facility to order the use of behavioral-shaping techniques.
- The period of placement alone in a room or other area shall not exceed thirty minutes.
- The patient shall be observed and supervised by a staff member.
- The period of placement alone in a room or other area shall not exceed a total of three hours in any twenty-four-hour time period. If the placement alone in a room or other area exceeds a total of three hours in any twenty-four-hour time period, it shall then be considered seclusion, which is prohibited.
- The date, time, and duration of the placement shall be documented.
- In treatment facilities where patients are placed alone in a room or other area as a behavior-shaping technique, there shall be written policies and procedures governing use of such behavior-shaping technique.

- 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:

The SMO is responsible for reporting use of time out to the OBH per its contract consistent with state law. The OBH is responsible for oversight concerning the use of time outs and ensuring that State safeguards are followed subject to individual facility accreditation. Oversight of incidents involving abuse or neglect is conducted through ongoing monitoring of Critical Incident/Incident Reports via a State approved on-line tracking system and OBH and the Health Standards Section will investigate incidents of complaints against providers involving immediate jeopardy, serious injuries, and other serious critical incidents. Unauthorized, over use or inappropriate use of time outs are detected through



the annual monitoring SMO conducts or as a result of Wraparound Facilitator's monthly contacts with child/youths and their legal representative(s), or as a result of receipt of a Critical Incident report. The SMO and OBH Program Manager ensure that all applicable state requirements have been followed regarding timeouts as part of the Critical Incident report review process. The OBH's contract with the SMO requires use of a State approved on-line tracking system as well as quarterly and annual reports to identify trends and patterns and support improvement strategies regarding Critical Incidents. This system allows the SMO and the OBH to work together to collect and compile data and use it to prevent reoccurrence of incidents. The OBH provides the Bureau of Health Services Financing with aggregate data and reports through the IMT which are inclusive of any reported restraint use, etc. Aggregate data is provided to the Medicaid Agency through the IMT on a quarterly basis and annual basis.

## 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.

Licensed provider agencies shall comply with licensing requirements governing medication management in that facility. Unlicensed provider agencies are required to have a pharmacist or physician complete quarterly medication/drug reviews for children taking medications with potentially serious side effects. The results of the review are reviewed by the SMO with the provider agency.

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

The SMO contract has policies and procedural precautions which must be implemented for medication management, which includes prohibited practices. Licensed provider agencies shall comply with licensing requirements governing medication management in that facility. Unlicensed provider agencies are required to have a pharmacist or physician complete quarterly medication/drug reviews for children taking medications with potentially serious side effects. The results of the review are reviewed by the state regulatory entities during annual or complaint reviews.

## Appendix G: Participant Safeguards

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

**c. Medication Administration by Waiver Providers**

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

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

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

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

Crisis Stabilization and Short Term Respite Care, when provided overnight, are the two waiver services required to be provided to waiver child/youths in licensed facilities.

State rules and regulations outline requirements for policies and procedures to be implemented for medication administration, including self-medication. Children who self-medicate are required to have an assessment on their ability to self-medicate and a physician must sign an order for self-medication. Documentation must be maintained as outlined in state rules/regulations.

- 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:

The specific types of medication error that providers must record are:

- administering the wrong drug, strength, or dose of medication;
- missed dosage;
- unauthorized dosage;
- wrong time of administration (more than 1 hour);
- incorrect route of administration;
- medication refusals
- wrong patient
- adverse drug reactions
- medication diversions

- 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.

The SMO is responsible for verifying that medication errors are recorded during regular annual on-site visits to providers. The SMO will report any critical errors to OBH. The SMO and OBH will ensure that all applicable state requirements have been followed regarding medication errors as part of the Critical Incident report review process. Aggregate data reports will be used through the Continuous Quality Improvement process and the IMT committee to identify recurrent problems with providers and prevent reoccurrence.

## 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, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.*

##### i. Performance Measures

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:

**Performance Measure: #1 Number and/or percent of reports related to the abuse, neglect, or exploitation of child/youths where an investigation was initiated within established time frames.**

##### Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**OBH performance monitoring**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

**Performance Measure:**

**Performance Measure: #2 Number and/or percent of child/youths who received information on how to report the suspected abuse, neglect, or exploitation of children.**

**Data Source (Select one):****Other**

If 'Other' is selected, specify:

**OBH performance monitoring**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>

<input checked="" type="checkbox"/> <b>Other</b> Specify: SMO	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div></div>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <div></div>
	<input type="checkbox"/> <b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div></div>

**Performance Measure:**

**Performance Measure: #3 Number and/or percent of child/youths who received information regarding their rights to a State Fair Hearing via the Notice of Action form.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample

		Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: Wraparound agencies
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

**Performance Measure:**

Performance Measure: #4 Number and/or percent of grievances filed by child/youths that were resolved within 14 calendar days according to approved waiver guidelines.

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input checked="" type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	

		<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input checked="" type="checkbox"/> <b>Other</b> Specify: SMO	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input checked="" type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**Performance Measure:**

**Performance Measure: #5 Number and/or percent of allegations of abuse, neglect, or exploitation investigated that were later substantiated.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**OBH abuse, neglect, or exploitation database**

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

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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.

N/A

**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.
- The SMO will address and correct problems identified on a case-by-case basis in accordance with its contract with the OBH. The OBH may require a corrective action plan for the problems identified. The OBH monitors the corrective action plan with the assistance of the Inter Departmental Monitoring Team. The SMO will notify the State immediately of any situation in which the health and safety of a child is jeopardized. This data is reported to the State Medicaid Agency (BHSF) on a monthly basis at the IMT meeting.

ii. **Remediation Data Aggregation**

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

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: ..... ^ v	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: ..... ^ v

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 QMS 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 QMS* 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 QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

## **Appendix H: Quality Improvement Strategy (2 of 2)**

### **H-1: Systems Improvement**

#### **a. System Improvements**

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

The Louisiana CSoc SED waiver operates under the umbrella of a 1915(b) waiver, and both State Plan behavioral health services and CSoc SED waiver services are delivered through a PIHP (the SMO) under the terms of a non-risk contract. Each waiver type has distinct requirements for quality management that are based on federal laws and regulations and are meant to ensure that the goals and intent of the respective waivers are met. During the initial waiver period, quality management programs and activities for each waiver will be developed and implemented separately. The SMO reports on performance measures and performance improvement projects and an External Quality Review (EQR) contract will be implemented in compliance with managed care regulations and 1915(b) waiver requirements. Quality management activities for the Louisiana CSoc SED waiver during the initial waiver period will include oversight of the SMO's implementation of processes and procedures to address 1915(c) waiver assurances, wraparound facilitator, oversight of plan implementation and service delivery and record reviews to identify any issues related to meeting assurances. As the services and populations covered by both waivers are interrelated and the infrastructure and processes for SMO oversight are put in place, the goal will be to better integrate quality management activities for all SMO Medicaid services and to begin to focus on quality improvement. At the same time, it will be necessary to ensure that the specific quality management requirements of each waiver

type continue to be met.

As stated above, performance measure reporting related mainly to state plan behavioral health services through the SMO will be implemented. The 1915(c) waiver application contains 35 performance measures specific to the CSOC SED waiver, which will be implemented and reported to the State through similar processes. The SMO will also ensure its reporting on grievances and appeals identifies those made specifically by or on behalf of LA CSOC SED waiver child/youths/applicants.

Quarterly quality management meetings with the BHSF, the OBH and the SMO will occur after implementation of the waiver program. The meetings will focus a great deal on implementation of the overall concurrent waiver program and activities specific to CSOC, including reporting requirements, refining of reports and implementation of EQR activities. This setting provides an excellent backdrop for operationalizing the LA CSOC SED performance measures and moving to the next level of trending, analyzing and setting benchmarks for all services delivered through the SMO

An Interdepartmental Monitoring Team (IMT) will meet with the SMO monthly, and conducts annual on-site reviews of SMO's operations in conjunction with the EQR. IMT activities will focus on a quality improvement, as well as implementation, with focus in both clinical and non-clinical areas.

The State and the SMO will implement corrective action plans based on specific monitoring activities (such as the annual on-site review). Appendix A of the application describes several discovery activities that the State Medicaid Agency will conduct in exercising its administrative authority over the waiver. All of these activities, including analysis of performance measure reporting, findings from IMT and external reviews, analysis of grievances and appeals reports, record reviews by the SMO and review of provider network for adequacy and choice will be the basis for an ongoing corrective action/quality improvement plan. The corrective action/quality improvement plan will be a working document that will identify areas for improvement, progress and target dates for completion. The areas for improvement will be prioritized and monitored on a day-to-day basis by the OBH waiver team and the OBH behavioral health section. Progress, issues and concerns will be presented to the IMT, which will serve as an advisory committee for the plan.

Through tracking and trending of performance reporting and findings from other oversight activities, the OBH and the SMO expects to be able to identify any provider specific and process-specific issues and implement corrective actions that will lead to overall quality improvement. As examples, with trending and tracking of complaints: a specific provider might be identified who needs additional training or even termination from the network; recurring and excessive delays in implementing service plans might result in changes in internal assessment/authorization processes; and as a final example, inconsistencies identified in level of care determinations could result in additional training to assure that staff have the same understanding of level of care criteria.

Progress on the corrective action/quality improvement plan will be presented quarterly to the IMT for comments and guidance. All LA CSOC SED related monitoring will be summarized and presented to CMS annually through the 372 report process and as requested.

## ii. System Improvement Activities

Responsible Party( <i>check each that applies</i> ):	Frequency of Monitoring and Analysis( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input type="checkbox"/> Annually
<input checked="" type="checkbox"/> Other Specify: SMO	<input checked="" type="checkbox"/> Other Specify: (monitoring)ongoing

## 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.

The effectiveness of system design changes – for example, a revised process to initiate the delivery of services more promptly – will be evident through ongoing monitoring activities using the same performance measures. Once performance measures are implemented and the SMO has an initial baseline year of service experience, the State and the SMO will jointly develop benchmark priorities. The OBH, quality management staff and the SMO will work jointly through the quarterly quality management meetings to assess system changes and begin developing benchmarks. The IMT will serve in an advisory capacity. The IMT monitors availability of services, delivery of network adequacy, timely access to care, cultural consideration, primary care and coordination/continuity of services, special healthcare needs, coverage and authorization of services, emergency and post-stabilization services, enrollment and disenrollment, grievance systems, health information systems, compliance with contract, and State and Federal Medicaid requirements.

QI reporting minimally includes statistical analysis, root cause analysis, analysis of barriers and improvement interventions. The quarterly presentations allow opportunity for dialogue, exchange of information and identification of best practices. As the committee process continues to develop, greater emphasis will be placed upon review, approval and evaluation of quality plans.

In addition, there will be quarterly meetings of the OBH/SMO quality management staff (referred to as the Quality Assurance and Performance Improvement (QAPI) Committee) to work on operational details to ensure that quality activities are consistent with QMS and contract requirements. Quarterly report results are documented in IMT meeting minutes and communicated to stakeholders and the QAPI Committee. The QAPI Committee reviews QMS activities and provides direction, feedback and support for strategic quality issues. These ongoing communications create a continuous feedback loop that impacts quality of care improvements for Medicaid child/youths. Quality results are reported to providers through plan mailings. Members and families receive QAPI activity information through member newsletters.

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

The quality improvement strategy for the waiver is incorporated in the managed care quality strategy as required by 42 CFR 438.202. The quality strategy is reviewed by the quality staff of the OBH through an ongoing process that incorporates input from a multitude of sources, including external stakeholders. The effectiveness of the quality strategy is reviewed on an annual basis and revised based upon analysis of results by the quality management staff in the OBH and the IMT. The quality strategy may be reviewed more frequently if significant changes occur that impact quality activities or threaten the potential effectiveness of the strategy. As a result of the annual analysis process, a quality plan for the upcoming year is developed that is compatible with the overall quality strategy. The development process begins with an assessment of the accomplishments of the prior year's quality plan, the EQR technical report, and incorporates input from committees and other established quality forums that include governmental agencies, providers, the SMO, children and advocates determining areas of focus for quality activities such as quality improvement measures, improvement projects and performance indicators.

## 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).

The OBH contract monitor staff meet monthly with the SMO's financial administrators to review financial reporting and budget items. The DHH also has a Division of Fiscal Management that routinely conducts audits of state held contracts. The director of this division is a child/youth of the IMT team meetings that reviews data and information

relative to the concurrent (b)(c) waiver.

The Division of Fiscal Management, OBH Fiscal staff, and the contract monitor will each receive a copy of the annual audit. The Division of Fiscal Management will review the audit and if it identifies any material issues, it will notify the contract monitor who will ask the PIHP to provide additional information. When a CPA does an audit, one of the items they are required to do is determine if the entity is financially viable for the next fiscal year. If they determine that they are not financially viable, then they are required to issue a "going concern" opinion.

The SMO by contract is required to have an accounting system with sufficient sophistication to maintain separate fund accountability and is required to have an independent audit of that system completed annually. This requirement is below.

#### Disclosure of Financial Records and Processes:

The SMO shall establish and maintain an accounting system in accordance with generally accepted accounting principles (GAAP). The costs properly applicable to Title XIX State Plan services, distinct from Title XIX 1915(c) waiver services, distinct from Title XIX 1915(b)(3) waiver services, distinct from the Non-Medicaid mental health services in this Contract and provided elsewhere by the SMO, shall be accounted for separately and readily ascertainable and auditable. The accounting system shall separately maintain records pertaining to the services and any other costs and expenditures made under this Contract separately for each funding stream.

The SMO and any subcontractors shall make available to the State, its agents, and appropriate federal representatives, any financial records of the SMO or subcontractors on a quarterly basis. Accounting procedures, policies and records shall be completely open to State and federal audit at any time during the Contract Period and for six years thereafter.

The Contract awarded by the State and all subcontractors shall include a provision that CMS, the HHS awarding agency, the US Comptroller General, HHS Inspector General, or any authorized federal representatives, shall have access to any books, documents, papers, and records of the SMO or subcontractors which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts, and transcriptions. HHS awarding agencies, the HHS Inspector General, the US Comptroller General, or any of their duly authorized representatives has the right of timely and unrestricted access to any books, documents, papers, or other records of the SMO or subcontractors that are pertinent to the awards, in order to make audits, examinations, excerpts, transcripts and copies of such documents. This right also includes timely and reasonable access to the subcontractors' personnel for the purpose of interview and discussion related to such documents. The rights of access in this paragraph are not limited to the required retention period, but shall last as long as records are retained.

#### Independent Audit:

The SMO shall submit an annual independently audited financial report that specifies the SMO's financial activities under the Contract within 6 months following the end of the SMO's fiscal year. The report should be sent to the DHH Division of Fiscal Management (DFM).

The report, prepared using GAAP or Statutory Accounting Principles as designated by the National Association of Insurance Commissioners (NAIC), must be prepared by an independent Certified Public Accountant selected from a list maintained by the Office of Legislative Auditor on a calendar year basis. The SMO shall send one copy of the report to the OBH, DFM, and the Office of the Legislative Auditor. The SMO is responsible for the cost of the audit.

The format and contents of the audit shall be negotiated by the OBH and the SMO, but shall include at a minimum:

- i. Balance Sheet,
- ii. Income Statement,
- iii. Statement of Cash Flows,
- iv. Statement of Retained Earnings,
- v. Notes and/or Footnotes to the Financial Statement

In addition to the audited financial statement requirements, OBH will prior approve a format for additional reporting requirements that will provide information regarding the following information that will be submitted no less than annually but may include quarterly and/or monthly reporting requirements.

1. A separate accounting for all revenues received from each of the reimbursement sources in the Contract (Title XIX, SED waiver, 1915(b)(3), administration, etc.);
2. Title XIX payments and non-risk Medicaid mental health payments;
3. Third party liability payment made by other third-party payers;
4. Receipts received from other insurers;
5. A breakdown of the costs of service provision, administrative support functions, plan management including documentation of the SMO's compliance; and
6. Assessment of the SMO's compliance with financial requirements or the Contract including compliance with requirements for insolvency protection surplus funds, working capital, and any additional requirements; and a separate letter from the independent Certified Public Accountant addressing non-material findings, if any.

The SMO will be required to comply with other prescribed compliance and review procedures. In addition to the annual audit, the SMO shall be required to submit to the OBH copies of the quarterly NAIC financial reports. A final reconciliation shall be completed by the independent auditing firm that conducted the annual audit. The final reconciliation shall make any required adjustments to estimates included in the audit completed within six months of the end of the Contract year. The final reconciliation shall be completed no later than twelve months following the end of the Contract year.

## 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.*

##### i. Performance Measures

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:

**Performance Measure: #1 Number and/or percent of providers that have payment recouped for waiver services provided without supporting documentation.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Routine Medicaid claims verification audits**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample

		Confidence Interval = 90%
<input checked="" type="checkbox"/> <b>Other</b> Specify: SMO	<input type="checkbox"/> <b>Annually</b>	<input checked="" type="checkbox"/> <b>Stratified</b> Describe Group: Wraparound agencies
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: SMO	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

**Performance Measure:**

**Performance Measure: #2 Number and/or percent of claims verified through the SMO's compliance audit to have paid in accordance with the child/youth's waiver service plan.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**SMO's compliance report**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: RAND sampling methodology recommended by OIG
	<input type="checkbox"/> Other Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

- 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.

The OBH will receive regularly occurring summaries from the SMO that identify the results of the routine Medicaid claims audits conducted by the Corporate Compliance division of the SMO as they are identified. Any waiver-specific proposed recoupments are reviewed by the OBH.

The SMO will also provides the OBH a summary report of all prior authorization activity for submission and approval of electronic plans of care by individual providers. This report is reviewed by the OBH on a continuous and ongoing basis.



**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.

The OBH reviews all proposed recoupments. The OBH makes recommendations regarding the need for technical assistance and potential formal responses. The OBH maintains access to the SMO prior authorization data system and conducts periodic reviews of the current prior authorization activity. The OBH's access to the prior authorization data system allows for the OBH to generate reports to facilitate this review.

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

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: SMO	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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).

Reimbursements for services are based upon a Medicaid fee schedule established by the State of Louisiana. The fee development methodology will build fees considering each component of provider costs as outlined below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the Plan are available to recipients at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. Provider enrollment

and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule. Except as otherwise noted in the Plan, the State-developed fee schedule is the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published on [www.lamedicaid.com](http://www.lamedicaid.com) and public notice is made consistent with Louisiana policy as required by CMS.

Sections 953 and 954 of the Louisiana Administrative Procedure Act (APA) describes the procedures governing the adoption, amendment and repeal of an administrative Rule as well as the filing and taking effect of Rules. The promulgation of an Emergency Rule (ER) or a Notice Of Intent (NOI) is one venue of public notice of a proposed change and is recognized as such by CMS. ERs and NOIs are published in the state's official journal, the Louisiana Register, on the 20th of the month.

The APA requires that a public hearing be conducted between 35 and 40 days following the publication of a NOI in the Register. Interested parties are permitted to give oral testimony or written comments at the hearing regarding the proposed Rule. An oversight report must be submitted to the applicable legislative committee containing a copy of the original or revised NOI (only non-substantive revisions can be made), written comments received and our responses, a roster of attendees and hearing certification. Louisiana must wait 30 days after the submission of the oversight report to afford the committee an opportunity to conduct hearings before we can proceed to finalize the Rule.

The fee schedule rate was set as of March 1, 2012 and is effective for services provided on or after that date.

The fee development methodology will primarily be composed of provider cost modeling, though Louisiana provider cost data and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in fee development.

- Staffing Assumptions and Staff Wages
- Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)
- Program-Related Expenses (e.g., supplies)
- Provider Overhead Expenses
- Program Billable Units

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

- 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 are submitted directly by the HCBS SED waiver provider(s) to the SMO MIS system. The SMO is required per contract to submit encounters to the MMIS.

## Appendix 1: Financial Accountability

### 1-2: 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 1-4-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 1-4-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:

When an individual has been determined clinically and financially eligible for HCBS CSoC SED Waiver services, the SMO send notification to OBH and BHSF who then review and notify the local eligibility work to indicate eligibility on the Medicaid eligibility system.

An electronic medical record or plan of care (POC) is developed for all child/youths served through the waiver in the electronic health record (EHR). All waiver services on the POCs are prior-authorized by the SMO. This plan of care is developed at the initial wraparound meeting. Communication between the Wraparound Agency and the SMO will occur to ensure that the POC is received, reviewed, and approvals are processed in a timely manner as detailed below.

When a waiver bill is submitted to the SMO, the SMO MIS electronically searches the POC database and the eligibility roster to ensure the child/youth was waiver eligible. The SMO MIS searches the provider file to assure the provider is enrolled with the PIHP and was approved to receive Medicaid waiver payment for the date of services.

The SMO conducts post pay reviews to validate waiver services were in fact provided as billed. This financial integrity review is included in the PIHP's fraud and abuse prevention and detection plan. This includes determining the accuracy of documentation, eligibility, services provided, units billed, and the treatment plan coincides with services authorized through the POC.

Additionally, the OBH and the SMO contractor perform quarterly chart and performance improvement reviews that compare services approved in the plan of care to service provided, eligibility, documentation, family choice, needs and strengths, goals and objectives, crisis plans, etc.

Providers must 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 SMO's electronic health record and database that captures services provided.

- 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**

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**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:

The SMO contract for children/youth services utilizes a non-risk payment methodology and requires the SMO to obtain an independent audit that reconciles all payments, including SED waiver payments, with the invoices and encounter data. The Medicaid fee schedule used to establish the invoices is equal to or less than the maximum allowable under the same Medicare rates, if applicable. If a service has no Louisiana-specific Medicare rate, Louisiana has established pricing based on similar services. Room and board costs are not included in the per member per months payments for the Title XIX members.

The SMO payments are as outlined in the cost-effectiveness portion of the 1915(b) waiver and the subsequent SMO contract. The payment may be adjusted based on applicable program changes, trend, etc. after each reconciliation. The final payment for 1915(c) SED services will not exceed what would have been paid had the same services been provided under the 1915(c) SED waiver. The OBH fiscal staff closely monitors this process for accuracy.

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**Appendix 1: Financial Accountability**


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**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.

No HCBS SED waiver services are excluded from the SMO.

## **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: *Complete item I-3-e.*

State and local behavioral health clinics may enroll as a qualified provider to provide any services under the waiver if they meet waiver provider qualification requirements.

## **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.

The SMO is paid on a non-risk basis for services provided to children/youth. The interim invoices are not reduced or returned to the state except through the approved non-risk reconciliation process per 42 CFR 447.362. The federal share of any funds returned to the state as a result of the reconciliation are returned to the federal government.

## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

#### g. Additional Payment Arrangements

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

- ☒ No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

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

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

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

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

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

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

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

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

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

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

**Appendix I: Financial Accountability****I-4: Non-Federal Matching Funds (1 of 3)**

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

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

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

Funds for the HCBS SED waiver are appropriated to the OBH. Payments to the SMO processed by the MMIS system are submitted to the State of Louisiana Central Accounting System managed by the Department of Administration. State of Louisiana Central Accounting System pays claims and debits the appropriate state agency fund. All financial transactions are monitored by the OBH and BHSF for compliance to Medicaid requirements.

☐ **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 1-2- 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 1-2-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 1-2- 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 1-4-a or 1-4-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:

The non-risk payments to the PIHPs are based on expenditures for services in the FFS waiver. FFS payment rates are based on the cost of providing the service exclusive of room and board. Other funding sources are used by the State and local governments to pay for room and board in licensed residential facilities.

## 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 (I 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-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

**Level(s) of Care:** Hospital, Nursing Facility

Col. 1 Year	Col. 2 Factor D	Col. 3 Factor D'	Col. 4 Total: D+D'	Col. 5 Factor G	Col. 6 Factor G'	Col. 7 Total: G+G'	Col. 8 Difference (Col 7 less Column4)
1	6279.00	10498.00	16777.00	6121.00	10838.00	16959.00	182.00
2	6648.00	11121.00	17769.00	6397.00	11701.00	18098.00	329.00
3	7034.00	11784.00	18818.00	6685.00	12635.00	19320.00	502.00
4	7448.67	12491.00	19939.67	6985.00	13393.00	20378.00	438.33
5	7888.93	13241.00	21129.93	7300.00	14197.00	21497.00	367.07

## 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 Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Hospital	Nursing Facility
Year 1	1200	1199	1
Year 2	1200	1199	1
Year 3	1200	1199	1
Year 4	1200	1199	1
Year 5	1200	1199	1

## 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.

Average length of stay on the waiver is estimated at 9 months or 270 days. This estimate is based on the ALOS for similar waivers in other states (KS and MD).

## 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:

Costs for waiver services are based on utilization projections for the waiver services and estimates of the rates to be paid for each service. The utilization projections are based on the utilization of similar services in other state waiver programs. The rates are based on modeling of the rates considering the typical compensation for workers in Louisiana. Finally, the estimated number of users of each service is based on information from other states related to the portion of the waiver population utilizing each waiver service.

Projections for years two through five incorporate considerations for utilization and cost trends of approximately 3% annually.

- 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 based on the historical utilization of other Medicaid State Plan services by children with SED. These costs are deemed a reasonable proxy for the other Medicaid costs for the waiver population.

Costs are projected based on trends in the historical data for Medicaid BH and PH services.

No children that incurred pharmacy expenses were dually eligible. Therefore, no adjustment was necessary for Medicare Part D.

Factor D' and Factor G' are very close for this initial waiver application. This is primarily due to the fact that the institutional level of care of inpatient psychiatric hospital has shorter lengths of stay than other levels of care in other 1915(c) waivers and the children that utilize inpatient psychiatric hospitals still access a number of services in the community after their hospital stays.

- 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 based on the costs and utilization of children served in an inpatient hospital for psychiatric treatment or a nursing facility for mental health. This includes psychiatric units of general hospitals as well as freestanding psychiatric hospitals and nursing facility stays for children with primary diagnoses of mental health. These costs are summarized from historical FY09 FFS data. During FY09, 12 inpatient stays for children were not captured in the FFS claims data. These stays totaled approximately \$900,000 and were paid in lump-sums to the hospitals. We included these Medicaid children and costs in the calculation of Factor G and G'. To project the costs into the waiver years, we projected using a 4.5% inflation factor. Any child enrolled in another 1915(c) waiver was excluded from this data.

- 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 based on the historical utilization of other Medicaid State Plan services by children who used inpatient psychiatric services or nursing facility for mental health. Actual costs for other State Plan services were summarized in this analysis from FY09 data. Any child enrolled in another 1915(c) waiver was

excluded from this data.

Costs are projected based on trends in the historical data for Medicaid BH and PH services.

No children that incurred pharmacy expenses were dually eligible. Therefore, no adjustment was necessary for Medicare Part D.

## 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	
Crisis Stabilization	
Independent Living/Skills Building	
Parent Support and Training	
Short-Term Respite	
Youth Support and Training	

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Crisis Stabilization Total:							617400.00
Crisis Stabilization	<input checked="" type="checkbox"/>	day	180	14.00	245.00	617400.00	
Independent Living/Skills Building Total:							74880.00
Independent Living/Skills Building	<input checked="" type="checkbox"/>	15 minute	60	160.00	7.80	74880.00	
Parent Support and Training Total:							3840000.00
<b>GRAND TOTAL:</b>							7534392.00
Total: Services included in capitation:							7534392.00
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							1200
Factor D (Divide total by number of participants):							6279.00
Services included in capitation:							6279.00
Services not included in capitation:							
Average Length of Stay on the Waiver:							270

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual	<input checked="" type="checkbox"/>	15 minute	1200	240.00	10.00	2880000.00	
Group	<input checked="" type="checkbox"/>	15 minute	1200	320.00	2.50	960000.00	
Short-Term Respite Total:							2426112.00
Short-Term Respite	<input checked="" type="checkbox"/>	15 minute	720	864.00	3.90	2426112.00	
Youth Support and Training Total:							576000.00
Youth Support and Training	<input checked="" type="checkbox"/>	15 minute	180	320.00	10.00	576000.00	
<b>GRAND TOTAL:</b>							7534392.00
Total: Services included in capitation:							7534392.00
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							1200
Factor D (Divide total by number of participants):							6279.00
Services included in capitation:							6279.00
Services not included in capitation:							
Average Length of Stay on the Waiver:							270

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Crisis Stabilization Total:							635922.00
Crisis Stabilization	<input checked="" type="checkbox"/>	day	180	14.00	252.35	635922.00	
Independent Living/Skills Building Total:							79497.00
Independent Living/Skills Building	<input checked="" type="checkbox"/>	15 minute	60	165.00	8.03	79497.00	
Parent Support and Training Total:							4074600.00
<b>GRAND TOTAL:</b>							7977855.00
Total: Services included in capitation:							7977855.00
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							1200
Factor D (Divide total by number of participants):							6648.00
Services included in capitation:							6648.00
Services not included in capitation:							
Average Length of Stay on the Waiver:							270

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual	<input checked="" type="checkbox"/>	15 minute	1200	247.00	10.30	3052920.00	
Group	<input checked="" type="checkbox"/>	15 minute	1200	330.00	2.58	1021680.00	
Short-Term Respite Total:							2576016.00
Short-Term Respite	<input checked="" type="checkbox"/>	15 minute	720	890.00	4.02	2576016.00	
Youth Support and Training Total:							611820.00
Youth Support and Training	<input checked="" type="checkbox"/>	15 minute	180	330.00	10.30	611820.00	
<b>GRAND TOTAL:</b>							7977855.00
Total: Services included in capitation:							7977855.00
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							1200
Factor D (Divide total by number of participants):							6648.00
Services included in capitation:							6648.00
Services not included in capitation:							
Average Length of Stay on the Waiver:							270

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Crisis Stabilization Total:							654998.40
Crisis Stabilization	<input checked="" type="checkbox"/>	day	180	14.00	259.92	654998.40	
Independent Living/Skills Building Total:							84354.00
Independent Living/Skills Building	<input checked="" type="checkbox"/>	15 minute	60	170.00	8.27	84354.00	
Parent Support and Training Total:							4319208.00
<b>GRAND TOTAL:</b>							8441286.00
Total: Services included in capitation:							8441286.00
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							1200
Factor D (Divide total by number of participants):							7034.00
Services included in capitation:							7034.00
Services not included in capitation:							
Average Length of Stay on the Waiver:							270

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual	<input checked="" type="checkbox"/>	15 minute	1200	254.00	10.61	3233928.00	
Group	<input checked="" type="checkbox"/>	15 minute	1200	340.00	2.66	1085280.00	
<b>Short-Term Respite Total:</b>							2733393.60
Short-Term Respite	<input checked="" type="checkbox"/>	15 minute	720	917.00	4.14	2733393.60	
<b>Youth Support and Training Total:</b>							649332.00
Youth Support and Training	<input checked="" type="checkbox"/>	15 minute	180	340.00	10.61	649332.00	
<b>GRAND TOTAL:</b>							8441286.00
Total: Services included in capitation:							8441286.00
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							1200
Factor D (Divide total by number of participants):							7034.00
Services included in capitation:							7034.00
Services not included in capitation:							
Average Length of Stay on the Waiver:							270

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Crisis Stabilization Total:</b>							674654.40
Crisis Stabilization	<input checked="" type="checkbox"/>	day	180	14.00	267.72	674654.40	
<b>Independent Living/Skills Building Total:</b>							89460.00
Independent Living/Skills Building	<input checked="" type="checkbox"/>	15 minute	60	175.00	8.52	89460.00	
<b>Parent Support and Training Total:</b>							4587192.00
<b>GRAND TOTAL:</b>							8938400.40
Total: Services included in capitation:							8938400.40
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							1200
Factor D (Divide total by number of participants):							7448.67
Services included in capitation:							7448.67
Services not included in capitation:							
Average Length of Stay on the Waiver:							270



Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual	<input checked="" type="checkbox"/>	15 minute	1200	262.00	10.93	3436392.00	
Group	<input checked="" type="checkbox"/>	15 minute	1200	350.00	2.74	1150800.00	
<b>Short-Term Respite Total:</b>							2898504.00
Short-Term Respite	<input checked="" type="checkbox"/>	15 minute	720	945.00	4.26	2898504.00	
<b>Youth Support and Training Total:</b>							688590.00
Youth Support and Training	<input checked="" type="checkbox"/>	15 minute	180	350.00	10.93	688590.00	
<b>GRAND TOTAL:</b>							8938400.40
Total: Services included in capitation:							8938400.40
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							1200
Factor D (Divide total by number of participants):							7448.67
Services included in capitation:							7448.67
Services not included in capitation:							
Average Length of Stay on the Waiver:							270

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Crisis Stabilization Total:</b>							694890.00
Crisis Stabilization	<input checked="" type="checkbox"/>	day	180	14.00	275.75	694890.00	
<b>Independent Living/Skills Building Total:</b>							94824.00
Independent Living/Skills Building	<input checked="" type="checkbox"/>	15 minute	60	180.00	8.78	94824.00	
<b>Parent Support and Training Total:</b>							4869864.00
<b>GRAND TOTAL:</b>							9466711.20
Total: Services included in capitation:							9466711.20
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							1200
Factor D (Divide total by number of participants):							7888.93
Services included in capitation:							7888.93
Services not included in capitation:							
Average Length of Stay on the Waiver:							270

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual	<input checked="" type="checkbox"/>	15 minute	1200	270.00	11.26	3648240.00	
Group	<input checked="" type="checkbox"/>	15 minute	1200	361.00	2.82	1221624.00	
<b>Short-Term Respite Total:</b>							3075458.40
Short-Term Respite	<input checked="" type="checkbox"/>	15 minute	720	973.00	4.39	3075458.40	
<b>Youth Support and Training Total:</b>							731674.80
Youth Support and Training	<input checked="" type="checkbox"/>	15 minute	180	361.00	11.26	731674.80	
<b>GRAND TOTAL:</b>							9466711.20
Total: Services included in capitation:							9466711.20
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							1200
Factor D (Divide total by number of participants):							7888.93
Services included in capitation:							7888.93
Services not included in capitation:							
Average Length of Stay on the Waiver:							270

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

### 1. Request Information

- A. The State of Louisiana 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:**  
Coordinated System of Care (CSoC) Severely Emotionally Disturbed (SED) Children's Waiver
- C. **Waiver Number:** LA.0889
- D. **Amendment Number:** LA.0889.R00.01
- E. **Proposed Effective Date:** (mm/dd/yy)  
06/22/13
- Approved Effective Date:** 07/19/13
- Approved Effective Date of Waiver being Amended:** 03/01/12

### 2. Purpose(s) of Amendment

**Purpose(s) of the Amendment.** Describe the purpose(s) of the amendment:

The purpose of the amendment is to include three additional parishes to the Region 1 geographic area, making this area include four parishes. Children and their families in the three additional parishes will be able to access services under the 1915 © waiver.

We are asking for an effective date upon approval. However as we are forced to place a date on this document, Regional CMS suggested using a date 2 months in the future and this date would be updated when the amendment was approved.

### 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 checked="" type="checkbox"/> Waiver Application	Main.4.C.Statewide
<input type="checkbox"/> Appendix A – Waiver Administration and Operation	
<input type="checkbox"/> Appendix B – Participant Access and Eligibility	
<input type="checkbox"/> Appendix C – Participant Services	
<input type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	
<input type="checkbox"/> Appendix E – Participant Direction of Services	
<input type="checkbox"/> Appendix F – Participant Rights	
<input type="checkbox"/> Appendix G – Participant Safeguards	
<input type="checkbox"/> Appendix H	
<input type="checkbox"/> Appendix I – Financial Accountability	
<input type="checkbox"/> Appendix J – Cost-Neutrality Demonstration	

- 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:

Adding access for waiver enrollment to include three additional parishes in a region/geographic area.

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

### 1. Request Information (1 of 3)

- A. The State of Louisiana 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):*  
Coordinated System of Care (CSoc) Severely Emotionally Disturbed (SED) Children's Waiver
- 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

Waiver Number: LA.0889.R00.01

Draft ID: LA.29.00.01

- D. Type of Waiver *(select only one):*

Regular Waiver

- E. Proposed Effective Date of Waiver being Amended: 03/01/12  
Approved Effective Date of Waiver being Amended: 03/01/12

### 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

Select applicable level of care

- ☒ Hospital as defined in 42 CFR §440.10

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

Psychiatric Care within a general hospital and inpatient psychiatric hospital for individuals under age 21 as provided in 42 CFR 440.160.

- ☐ Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

- ☒ Nursing Facility

Select applicable level of care

- ☒ Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

N/A

- ☐ Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

- ☐ Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:



## 1. Request Information (3 of 3)

### G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

☐ Not applicable

☒ Applicable

Check the applicable authority or authorities:

☐ Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

☒ Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Louisiana Behavioral Health Services 1915(b) waiver which is being submitted at the same time as this waiver will operate concurrently with this waiver.

Specify the §1915(b) authorities under which this program operates (check each that applies):

☒ §1915(b)(1) (mandated enrollment to managed care)

☐ §1915(b)(2) (central broker)

☒ §1915(b)(3) (employ cost savings to furnish additional services)

☒ §1915(b)(4) (selective contracting/limit number of providers)

☐ A program operated under §1932(a) of the Act.

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ A program authorized under §1915(i) of the Act.

☐ A program authorized under §1915(j) of the Act.

☐ A program authorized under §1115 of the Act.

Specify the program:

### H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

☒ This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

## 2. Brief Waiver Description

**Brief Waiver Description.** In one page or less, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The HCBS SED waiver is designed as a nursing facility and hospitalization diversion program. The goal of the SED waiver is to divert nursing facility and psychiatric hospitalization placement through the provision of intensive home and community-based supportive services in an effort to maintain children and youth in their home and community.

The Louisiana SED waiver provides to child/youths and their families five services not available to other Medicaid youth. These services are: Independent Living/Skills Building, Short term respite, Youth Support and Training, Parent Support and Training, and Crisis Stabilization.

Child/youths eligible for the waiver are between the ages of birth up to and including age 21.

Both clinical and financial criteria must be met to be eligible for the waiver. The clinical assessment is a multi-step process. A child/youth must have a mental health diagnosis determined by physician or licensed mental health professional (LMHP)

and qualifying scores on a standardized assessment tool, the Child and Adolescent Needs and Strengths (CANS) Comprehensive Multisystem Assessment. Financial eligibility is determined by DHH Medicaid eligibility workers.

The waiver is managed by the Operating Agency, Office of Behavioral Health (OBH), which is a division within the single state agency Louisiana Department of Health and Hospitals (DHH). SED waiver services are provided by the Statewide Management Organization (SMO) and by Wraparound Agencies. The OBH contracts with a Prepaid Inpatient Health Plan (PIHP), also known as the SMO, to review and authorize waiver services through the SMO's database and Electronic Health Record system. The OBH has access to the SMO's database and Electronic Health Record system.

The five waiver services can only be delivered by providers in accordance with the concurrent Louisiana 1915(b) waiver who are credentialed, enrolled and paid by the SMO. The providers must meet both state licensing and HCBS provider requirements.

### 3. Components of the Waiver Request

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The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
 

☐ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*

☒ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

### 4. Waiver(s) Requested

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- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):



- ☐ Not Applicable
- ☐ No
- ☒ Yes

**C. Statewide**ness. Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

- ☐ No
- ☒ Yes

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

☒ **Geographic Limitation.** A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

Individuals in five regions may enroll in the CSoc 1915(c) SED waiver on March 1, 2012.

- Region 2 includes the parishes of East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, and West Feliciana.
  - Region 7 includes the parishes of Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, and Winn.
  - Region 8 includes the parishes of Bienville, Bossier, Caddo, Claiborne, Desoto, Jackson, Natchitoches, Red River, Sabine, and Webster.
  - Region 9 includes the parishes of Caldwell, East Carroll, Franklin, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, and West Carroll.
  - Jefferson Parish (Part of Act 1225 Region 1)
- \* Effective upon approval, all of the Act 1225 Region 1 parishes will offer enrollment in the SED 1915 (c) waiver. Parishes added are St. Bernard, Plaquemines and Orleans.

No other firm implementation plans exist for additional phase-in. Waiver and contract amendments will be submitted to CMS when and if additional Regions/Parishes are implemented.

☐ **Limited Implementation of Participant-Direction.** A waiver of statewide requirements is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

*Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

**A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.



- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
  - 1. Informed of any feasible alternatives under the waiver; and,
  - 2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their



projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who 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. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:  
 Nine Town Hall Meetings were held announcing this program from February 17 – March 3, 2011 throughout the State, explaining the waivers, and gathering input. Copies of the presentation for those Town Halls can be found at [www.dcfslouisiana.gov/index.cfm?md=pagebuilder&tmp=home&pid=272](http://www.dcfslouisiana.gov/index.cfm?md=pagebuilder&tmp=home&pid=272)  
 A press release was issued on March 3, 2011. A newspaper notice in the state's eight major daily newspapers as well as the Louisiana Register was placed on March 11, 2011 notifying the public of the availability of proposed State Plan Amendments including reimbursement changes, proposed 1915(c) and 1915(b) waivers as well as the public meeting on March 28, 2011.

The newspaper notice listed the availability of the documents on the Coordinated System of Care website <http://www.dcfslouisiana.gov/index.cfm?md=pagebuilder&tmp=home&pid=272> as well as the DHH website. The State begins the rulemaking process during the month of March. That rulemaking process will also include a full public notice process that will be completed prior to implementation. A report to the appropriate Legislative Oversight Committee will be made in accordance with the Administrative Procedures



Act. Full Legislative analysis and briefings will be prepared and held as part of the rulemaking process.

Sections 953 and 954 of the Louisiana Administrative Procedure Act (APA) describes the procedures governing the adoption, amendment and repeal of an administrative Rule as well as the filing and taking effect of Rules. The promulgation of an Emergency Rule (ER) or a Notice Of Intent (NOI) is one venue of public notice of a proposed change and is recognized as such by CMS. ERs and NOIs are published in the state's official journal, the Louisiana Register, on the 20th of the month.

The APA requires that a public hearing be conducted between 35 and 40 days following the publication of a NOI in the Register. Interested parties are permitted to give oral testimony or written comments at the hearing regarding the proposed Rule. An oversight report must be submitted to the applicable legislative committee containing a copy of the original or revised NOI (only non-substantive revisions can be made), written comments received and our responses, a roster of attendees and hearing certification. We must wait 30 days after the submission of the oversight report to afford the committee an opportunity to conduct hearings before we can proceed to finalize the Rule.

**J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

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**A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:**

Owen

**First Name:**

Lou Ann

**Title:**

Deputy Medicaid Director

**Agency:**

Department of Health and Hospitals

**Address:**

628 N. 4th Street

**Address 2:**

**City:**

Baton Rouge

**State:**

Louisiana

**Zip:**

70821-9030

**Phone:**

(225) 342-9767

**Ext:**

☐ TTY

**Fax:**

(225) 342-9508

**E-mail:**

LouAnn.Owen@LA.gov

**B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:****Last Name:**

Gradney

**First Name:**

Charlene

**Title:**

DHH Program Manager 2

**Agency:**

Office of Behavioral Health

**Address:**

628 N. 4th Street, Room 472

**Address 2:****City:**

Baton Rouge

**State:**

Louisiana

**Zip:**

70802-4049

**Phone:**

(225) 342-9239

**Ext:**☐ TTY**Fax:**

(225) 342-5066

**E-mail:**

charlene.gradney@la.gov

## 8. Authorizing Signature

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This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

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**Signature:**

Timothy White

State Medicaid Director or Designee

**Submission Date:**

Apr 24, 2013

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**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

**Last Name:** Kennedy

**First Name:** Ruth

**Title:** Medicaid Director

**Agency:** BHSF

**Address:** 628 N 4th Street., 7th Floor

**Address 2:**

**City:** Baton Rouge

**State:** Louisiana

**Zip:** 70802

**Phone:** (225) 342-3032 **Ext:** ☐ TTY

**Fax:** (225) 342-9508

**E-mail:**

**Attachment #1:** ruth.kennedy@la.gov

### Transition Plan

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Specify the transition plan for the waiver:

As the SMO is implemented, youth transitioning onto the SED waiver will be enrolled in the new PIHP network which is a non-risk health care delivery system. To ensure a smooth transition, children currently eligible for Medicaid FFS Mental Health Rehabilitation and clinic services and are in one of the regions covered by the SED waiver will be screened to determine if they are eligible for the SED waiver. Any child found to be eligible for the SED waiver will have their current services reviewed and continued as needed through the Child and Family Team Process care planning process described in Appendix D.

Individuals in five regions may enroll in the CSoC 1915(c) SED waiver on March 1, 2012.

- Region 2 includes the parishes of East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, and West Feliciana.
  - Region 7 includes the parishes of Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, and Winn.
  - Region 8 includes the parishes of Bienville, Bossier, Caddo, Claiborne, Desoto, Jackson, Natchitoches, Red River, Sabine, and Webster.
  - Region 9 includes the parishes of Caldwell, East Carroll, Franklin, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, and West Carroll.
  - Jefferson Parish (Part of Act 1225 Region 1)
- \* Effective upon approval, all of the Act 1225 Region 1 parishes will offer enrollment in the SED 1915(c) waiver. Parishes added are St. Bernard, Plaquemines and Orleans.



No other firm implementation plans exist for additional phase-in. Waiver and contract amendments will be submitted to CMS when and if additional Regions/Parishes are implemented.

#### Additional Needed Information (Optional)

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Provide additional needed information for the waiver (optional):

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