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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

A. The **State** of **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:
Community Choices (CC) Waiver

C. Waiver Number:LA.0866

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
01/01/26

Approved Effective Date of Waiver being Amended: 07/01/24

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

Changes in this amendment include:

- B-3.a.: Updated/increased the unduplicated # of participants for years 2-5.
- B-3.b.: Updated/increased the maximum # of participants at any point in the years 2-5.
- B-6.f.: Added details regarding the process for initial tasks for the Initial Plan of Care Development.
- C-1/C-3: Assistive Devices and Medical Supplies (ADMS)- Added language to indicate that these services can also be available to participants during transition from a nursing facility to the community.
- I-2.a.: Added the Rate Determination Methods for Initial Plan of Care Development.
- C-1/C-3: Environmental Accessibility Adaptations (EAA) - Added the word "modification" to the service definition for clarification purposes.
- J-1: Composite Overview was updated for years 2-5 due to the addition of Initial Plan of Care Development under the "Support Coordination" service in Factor D.
- J-2-a.: Updated the # of unduplicated participants by NFLOC to match the #s in B-3.a.
- J-2:c.i.: Added language for the Factor D Derivation to include the cost estimates for the Initial Plan of Care Development.
- J-2:d.i.: Added the Initial Plan of Care Development estimates of Factor D for years 2-5.

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)
☐ **Waiver Application**	
☐ **Appendix A - Waiver Administration and Operation**	
☒ **Appendix B - Participant Access and Eligibility**	B.3.a.; B.3.b.; B.6.f.
☒ **Appendix C - Participant Services**	C-1/C-3
☐ **Appendix D - Participant Centered Service Planning and Delivery**	D-1:d.i.
☐ **Appendix E - Participant Direction of Services**	
☐ **Appendix F - Participant Rights**	
☐ **Appendix G - Participant Safeguards**	
☐ **Appendix H**	
☒ **Appendix I - Financial Accountability**	I-2. a.
☒ **Appendix J - Cost-Neutrality Demonstration**	J-1, J-2.c.i., J-2:d.i.

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:

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 section 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*):

Community Choices (CC) 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**

Draft ID: **LA.025.03.03**

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/24
Approved Effective Date of Waiver being Amended: 07/01/24

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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:

○ **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:

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

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID 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 section 1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under section 1915(b) of the Act.**

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

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

☐ **section 1915(b)(1) (mandated enrollment to managed care)**

☐ **section 1915(b)(2) (central broker)**

☐ **section 1915(b)(3) (employ cost savings to furnish additional services)**

☐ **section 1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under section 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 section 1915(i) of the Act.**

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

☐ **A program authorized under section 1115 of the Act.**

Specify the program:

H. Dual Eligiblity 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 Community Choices(CC) Waiver, a 1915(c) waiver, is designed to enhance the home and community-based services available to individuals who would otherwise require care in a nursing facility.

The goals and objectives of the CC Waiver are:

GOALS

1. To provide home and community-based services to individuals age 65 and older who are Medicaid eligible and meet nursing facility level of care; and adults with physical disabilities age 21 - 64 who are disabled according to Medicaid standards or SSI disability criteria, Medicaid eligible, and meet nursing facility level of care;
2. To promote participants' freedom to make choices in their lives;
3. To promote participants' self-determination in exercising control over how, where, and with whom their lives will be lived;
4. To ensure participant health and welfare;
5. To ensure that participants have the support and assistance desired to care for themselves and engage in the community;
6. To promote participant self-determination in identifying appropriate supports and/or services; and
7. To enhance participants' informal supports.

OBJECTIVES

1. To implement Quality Improvement Strategies (QIS) to ensure the health and welfare of the participant;
2. To allow the participant choice in selecting providers and support coordination agencies through Freedom of Choice process;
3. To develop an individualized, person centered plan of care that embraces participants' self-determination and which is responsive to the participants' needs and preferences;
4. To allow the participant the choice between institutional care and home and community-based services; and
5. To ensure that only qualified providers and support coordination agencies will serve the participant.

The Louisiana Department of Health (LDH) is the cabinet-level “umbrella” agency for the major publicly-funded health and long-term care programs in Louisiana. The administering, operating, and licensing agencies for the CC Waiver are located within LDH. Within LDH, the Bureau of Health Services Financing (BHSF) is responsible for the administration of the state Medicaid program and is the administering agency for the CC Waiver. The Office of Aging and Adult Services (OAAS) serves as the operating agency for the CC Waiver and is the policy and program agency for older adults and people with adult-onset disabilities. The Health Standards Section(HSS)serves as the licensing agency for the state and is responsible for the licensing and oversight of CC Waiver providers. All agencies reporting to the same cabinet Secretary enables close collaboration, coordination, and oversight.

Sections within BHSF are responsible for provider enrollment, determination of rate setting, claims payment/management, fraud prevention/discovery/remediation, and monitoring of OAAS as the Operating Agency for the CC Waiver. BHSF and OAAS serve jointly as contract monitors for the point of entry contractor.

OAAS operates the CC Waiver through its three divisions for Policy, Research & Quality, and Program Operations; and through its nine regional offices. The CC Waiver is accessed through the OAAS single point of entry contractor and the Louisiana Options in Long Term Care Help Line. When criteria are met, the individual's name is placed on the CC Waiver Request for Services Registry (RFSR) until a waiver offer becomes available. When the individual is offered the CC Waiver, he/she may accept or deny the offer. If the individual accepts the offer, he/she chooses a support coordination agency through the Freedom of Choice (FOC) process. The support coordination agency then offers FOC of provider(s). Once the individual is found eligible for waiver services, OAAS or its designee must approve the individual's plan of care (POC). All services must be prior authorized and delivered in accordance with the approved POC.

The CC Waiver affords participants the opportunity to select a traditional service delivery method or to Self-Direct services. Either option promotes self-determination principles for our population to maintain as much independence and control over their lives as feasible.

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 section 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 section 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. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in section 1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness 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:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness 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 section 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

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/IID.

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 section 1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR Part 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. 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 Part 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:

In accordance with 42 CFR 441.304, the State's intention to amend the current Community Choices Waiver application and a summary description of changes were published in eight major Louisiana newspapers on XXXXX. The entire waiver amendment application was also made available on the OAAS website and at each OAAS Regional Office for public review and comment for a period of 30 calendar days prior to the submission to CMS for approval. The public comment period was XXXX through XXXX.

The Department's public notice and input processes for this amendment consisted of the following:

1. The State published the public notice in the 8 major daily newspapers of the State with the largest circulation. They were published in the following cities: Lafayette, Baton Rouge, New Orleans, Alexandria, Shreveport, Monroe, Lake Charles, and Houma. The public notice appeared in the Legal Ad Section of the hard copy newspapers and was published electronically on the Louisiana Press Association website. Within the public notice, we provided information on how to access the waiver amendment application and provide comments and feed back in both hard copy and electronic forms. The following language appeared in the public notice:

   "The Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF) and the Office of Aging and Adult Services (OAAS) currently provide home and community-based services through the Community Choices (CC) Waiver to eligible Medicaid participants. The Department hereby gives public notice of its intent to submit an application for a waiver amendment to the U.S. Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) in order to amend services in the CC Waiver. The amendment of this waiver is contingent upon CMS approval.

   In compliance with CMS requirements, the Department is posting the CC Waiver amendment application (LA.0866.R03.03) for public comment from September 12, 2025 through October 12, 2025. CMS regulations require LDH to actively engage the public and give program participants, advocates, providers and other community stakeholders the opportunity to provide input regarding changes made to current waiver applications prior to the submission of final versions to CMS.

   The CC Waiver amendment application is posted to the OAAS website and may be accessed at the following address: http://www.ldh.la.gov/news/7566. A hard copy of the amendment may be requested by calling the OAAS Help Line at 1-866-758-5035 and is available for viewing at the OAAS Regional Offices (ROs). The location of the OAAS RO in your region can be found at: https://ldh.la.gov/microsite/12 or by calling the OAAS Help Line at 1-866-758-5035.

   Interested persons may submit written comments to the Office of Aging and Adult Services, P.O. Box 2031 (Bin #14), Baton Rouge, LA 70821-2031 or by email to OAASDocumentsRequests@LA.GOV. The deadline for receipt of all written comments is October 12, 2025 by 4:30 p.m."

   The entire Community Choices Waiver amendment application and instructions for submitting comments (both hard copy and electronically) were posted for public comment from September 12, 2025 through October 12, 2025 on the OAAS website at web address: http://www.ldh.la.gov/news/7566.

   The tribal notice for this Community Choices Waiver amendment application was sent to the tribes on September 12, 2025.

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: Bennett

First Name: Toni

Title: Section Chief

Agency: Bureau of Health Services Financing

Address: P.O. Box 91030

Address 2: 628 North Fourth Street-6th Floor

City: Baton Rouge

State: **Louisiana**

Zip: 70821-9030

Phone: (225) 342-6332 **Ext:** ☐ **TTY**

Fax: (225) 389-8033

E-mail: Toni.Bennett@LA.GOV

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

Last Name: Williams

First Name: Gearry

Title: Assistant Secretary

Agency: Office of Aging and Adult Services

Address: P.O. Box 2031

Address 2: 628 North Fourth Street - 2nd Floor

City: Baton Rouge

State: **Louisiana**

Zip: 70821-2031

Phone: (225) 219-0223 **Ext:** ☐ **TTY**

Fax: (225) 219-0201

E-mail: Gearry.Williams3@LA.gov

8. Authorizing Signature

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 section 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.

Signature: Toni Bennett

State Medicaid Director or Designee

Submission Date: Apr 23, 2025

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

Last Name: Bennett

First Name: Toni

Title: Section Chief

Agency: Bureau of Health Services Financing

Address:

P.O. Box 91030 Bin 24

Address 2:

628 North Fourth Street-6th Floor

City:

Baton Rouge

State: **Louisiana**

Zip:

70821-9030

Phone:

(225) 342-6332 **Ext:** ☐ **TTY**

Fax:

(225) 389-8033

E-mail:

Toni.Bennett@la.gov

Attachments

Attachment #1: Transition Plan

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

☐ **Replacing an approved waiver with this waiver.**

☐ **Combining waivers.**

☐ **Splitting one waiver into two waivers.**

☐ **Eliminating a service.**

☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**

☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

☐ **Reducing the unduplicated count of participants (Factor C).**

☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**

☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Additions from Appendix I-1:

Collectively, these alerts provide a robust defense against fraudulent activities in the healthcare system, allowing for timely intervention and the preservation of valuable resources. They empower LDH to uphold integrity, compliance, and operational efficiency by converting the information into an actionable preliminary investigation.

LDH's Case Tracking system streamlines the automated assignment of preliminary cases directly to investigators, seamlessly integrating Fraud Detect, MCO Tips, and public complaints. Publicly submitted complaints and tips are generated electronically through the connection between LDH's phone system and MCO 145 reporting. When Fraud Detect flags a case, it enters the Case Tracking system, where referrals, complaints, and tips related to potential Medicaid program violations are documented and routed to the specialized Special Investigations team within LDH.

The Special Investigations team plays a pivotal role in this endeavor by conducting preliminary investigations. They thoroughly examine flagged cases, leveraging the comprehensive data and insights provided by Fraud Detect to assess the validity and severity of billing anomalies.
SURS unit is compliant with 42 CFR § 455.13 and 42 CFR § 455.14 that states if the agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation. SURS will receive complaints, referrals, data mining leads and tips that identify potential questionable practices. Once the information is received a preliminary investigation is done, the case is either closed with a resolution or moved into a full investigation if a more comprehensive review is needed.

SURS unit is complaint with 42 CFR §455.21 which requires States with a Medicaid fraud control unit established and certified under subpart C of this part, The agency must refer all cases of suspected provider fraud to the unit. If the unit determines that it may be useful in carrying out the unit's responsibilities, promptly comply with a request from the unit for PI will provide Access to any records or information kept by the agency or its contractors. Upon referral from the unit, initiate any available administrative or judicial action to recover improper payments to a provider.

SURS unit conducts programmatic assessments and make recommendations regarding system enhancements, law/policy/contract provisions, and identifies and refers issues of particular significance to SURS. PI utilizes risk models by performing a deep dive on each provider type by factoring current FWA schemes, SIRIS and HFPP data, and provider anomalies.

LDH Programs submit referral of policy violation to SURS unit encouraging providers self-reporting. In so doing, providers can mitigate additional risk exposure, minimize penalty and present to the Department and law enforcement that they do not support nor condone improper, unethical and illegal activities of their employees.

SURS unit is complaint with 42 CFR §455.20 (a) requires the State to have a method for verifying with recipients whether services billed by providers were received. Agency must have means of beneficiary verification of services paid on their behalf. Medicaid sends out recipient explanation of benefits (REOMB) to recipients where service was provided. If the recipient reviews the REOMB and determines services described were not provided, SURS unit will receive a call, email or correspondence from recipient where provider will be review for services not rendered prior to opening a full investigation.

The provided information describes the workflow involved in the Medicaid Program Integrity investigation process. This workflow is crucial for maintaining compliance among Medicaid providers and identifying potential overpayments. At the outset, the workflow status and sub-status indicators serve as tracking tools to monitor the progress of individual cases.

The Management Compliance Incident stage marks the initiation of a case's investigation and comprises several sub-stages. In New Case Assigned, an initial review of provider and beneficiary history is conducted to identify the area of investigation. Subsequently, in Overview Analysis, analysts perform an in-depth assessment of provider history, payments, eligibility, and case initiation issues. This is followed by Researching, where analysts gather information from various sources, including Medicaid policies and previous sanctions. In Data Review, analysts examine claims history to determine the scope of the review. Statistical Sample involves a detailed analysis of scientific sample reports. The Record Review sub-stage entails collecting and organizing relevant documents. Policy Clarification involves reviewing Medicaid policies, and Consultant Review requires collaboration with medical experts. Analysts calculate initial overpayments in Initial Findings, and cases are then submitted for Quality Control in Quality Control. In exceptional cases, investigations may temporarily be On Hold.

Under the Medical Assistance Program Integrity Law (MAPIL) in Louisiana, providers have rights and avenues of appeal when they are accused of fraud, waste, abuse, or other ill practices related to the medical assistance programs. MAPIL is designed to combat and prevent fraud and abuse within these programs and protect their fiscal and programmatic integrity. The law empowers the Secretary of the Department of Health and Hospitals, the Attorney General, and even private citizens of Louisiana

to act as agents of the state in pursuing civil monetary penalties, liquidated damages, or other remedies against healthcare providers and individuals engaged in fraudulent activities that result in unwarranted payments.

Providers accused of fraudulent or abusive practices have the right to appeal these accusations. The appeal process provides them with the opportunity to challenge the allegations and defend their actions. This process typically involves several steps, including notification of the allegations, an opportunity to present evidence and arguments, and a formal review by a designated authority or administrative body.

Throughout the appeal process, providers are entitled to due process rights, including the right to legal representation, the right to be heard, and the right to a fair and impartial review. These safeguards are crucial to ensure that providers are given a fair chance to contest the accusations and present their side of the case.

While the specifics of the appeal process and the rights of providers may vary depending on the circumstances and procedures outlined in MAPIL, the overall intention is to ensure a fair and transparent process for addressing allegations of fraud and abuse within the medical assistance programs in Louisiana. This approach helps protect both the integrity of these programs and the rights of healthcare providers who may be subject to allegations.

Under the provisions of the Medical Assistance Program Integrity Law (MAPIL) in Louisiana, the state possesses the authority to take various adverse actions against healthcare providers and individuals found to have engaged in fraudulent or abusive practices within the medical assistance programs. These actions are implemented to uphold the fiscal and programmatic integrity of these healthcare programs. Adverse actions available under MAPIL encompass a range of measures, such as the imposition of Civil Monetary Penalties (CMPs) and liquidated damages, both of which involve financial penalties. The state may seek to recoup overpayments made as a result of fraudulent activities, while also having the power to temporarily or permanently exclude wrongdoers from participating in the medical assistance programs.

In cases of severe misconduct, MAPIL permits the state to refer matters for criminal prosecution, potentially leading to fines, imprisonment, or other legal consequences. Moreover, it grants the state authority to suspend payments to providers or individuals during the investigation of alleged fraud or abuse to safeguard program funds. Providers found guilty of fraud or abuse may also face sanctions, including the revocation of their professional licenses or certifications necessary for program participation. Additionally, the law may offer flexibility for the pursuit of other suitable remedies to address specific instances of misconduct within the medical assistance programs. These adverse actions are integral to deterring fraudulent and abusive behavior, recovering misappropriated funds, and preserving the integrity of Louisiana's medical assistance programs.

Upon the identification of an overpayment, SURS initiates a process to address this issue. An initial step involves sending a notification to LDH Fiscal to establish a negative balance on the provider's online record. This negative balance is used to reconcile payments through remittance advices or, in cases where providers submit checks via postal mail, through offline means. Critical information provided to Fiscal includes the recoupment amount, provider name and number, and the dates of the review. As part of this process, a copy of the provider recoupment letter is sent to serve as supplementary documentation. Fiscal, in turn, undertakes the necessary paperwork, including the completion of the CMS-64 form, to facilitate the return of the federal share within the prescribed timeframes stipulated by CMS. The provider is notified through a recoupment letter that specifies the areas of review. Within this framework, the provider maintains the option to submit additional information, request an informal hearing with LDH, or seek an appeal. Furthermore, the provider has the flexibility to either remit the full overpayment amount or propose a payment plan. In addition to the recovery of overpayments, SURS may also request the formulation of a corrective action plan to address any billing or programmatic issues identified during the review process. This multifaceted approach ensures the resolution of overpayment issues while allowing providers avenues to self-report.

Post payment reviews are conducted throughout the year. Cases are open based on various sources. The Surveillance and Utilization Review Subsystem (SURS) program under the state’s Medicaid Program Integrity section operates a hotline where complaint calls are received that pertain to fraud, waste and abuse. Additionally, SURS receives complaints via the Louisiana Department of Health website, mail and fax. Complaint cases are triaged and then opened each month. Another source of cases openings is Recipient Explanation of Benefits (REOMBs). Each month, REOMBs are sent to a random sample of recipients, and based on the recipients' responses, cases are opened. Cases are also opened as a result of data mining. Data mining runs are done throughout the year. Some runs like the Surge Run and the HCPCS Outlier run are done annually, and cases are opened based on the results, and other runs like Home and Community-Based Services (HCBS) and Inpatient Stay overlaps are done periodically.

Additions from I-2:a (cont'd with FMS language)
Each provider will submit its cost data at least every 5 years to determine if a change in the base rate is warranted. The add-on component for criminal BGC's will be re-calculated using actual cost data from providers at least every five years. Ability to adjust rates is contingent on the availability of appropriated funding in the state budget.

Appendix A: Waiver Administration and Operation

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.

(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:

Office of Aging and Adult Services (OAAS)

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:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

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:

BHSF and OAAS have a common and concurrent interest in providing Medicaid eligible individuals access to waivers and other identified services through qualified providers, while ensuring the integrity of the Medicaid program is maintained.

The Louisiana Department of Health (LDH) is the umbrella agency designated as the Single State Medicaid Agency. Within LDH, BHSF is responsible for the administration of the state Medicaid program and is the administering agency for the CC Waiver. OAAS is also located with LDH and is the operating agency for the CC Waiver. BHSF and OAAS have an Interagency Agreement (IA) defining the responsibilities of each. The IA is to be reviewed yearly and updated as necessary. Among other activities, this IA requires BHSF and OAAS to meet quarterly to evaluate the waiver program and initiate necessary changes to policy and/or reimbursement rates and to meet quarterly with the Division of Health Economics to review the financial accountability reports for the waiver program.

There are nine (9) OAAS Regional Offices (ROs) within the state of Louisiana which perform regional waiver operation functions for the OAAS waivers as delegated and described in the CMS approved waiver document. The OAAS waiver offices perform under the guidance and supervision of OAAS, the state waiver operating agency. The OAAS waiver offices must comply with all regional Quality Improvement Strategy activities as described in the approved waiver document. Both the state operating agency (OAAS)and each of the OAAS regional operating offices share responsibility to meet the federally mandated assurances and sub-assurances for: Level of Care; Service Plan; and Health and Welfare.

To ensure compliance with federal regulations governing waivers, BHSF created the Medicaid Program Support and Waivers Section (MPSW) which oversees the administration of the Medicaid Home and Community Based Services (HCBS) programs operated by OAAS and the Office for Citizens with Developmental Disabilities (OCDD). Oversight is completed under the direction of the Medicaid Program Support and Waivers Section Chief.

BHSF oversight of operating agency performance is facilitated through the following committees:

LDH Variance Committee – meets at least quarterly to review financial utilization and expenditure performance of all OAAS waivers. Members are composed of representatives from OAAS, BHSF Division of Health Economics, LDH Finance/Budget, MPSW, and other BHSF sections as needed.

Medicaid HCBS Oversight Committee - meets at least quarterly with the specific purpose to ensure required oversight of the OAAS operated HCBS Medicaid programs. Goals are to review current performance reports, determine need for new activities concerning quality and oversight in waiver programs and ensure adequate remediation enforcement. Quality recommendations or
issues which cannot be resolved at this level are placed on the agenda of the Medicaid/Program Offices Quarterly Meeting. Members include HCBS quality management staff from MPSW and OAAS and it is chaired by the MPSW Section Chief or designee. Standing agenda items for the HCBS Oversight Committee include:

--OAAS operating agency staff present their analysis of all performance measure findings, remediation activities and systemic improvements to MPSW as defined in the 1915(c) waiver quality strategy;
--MPSW Section Chief or designee monitors quarterly/annual activities to ensure data collection, analysis, and remediation is occurring according to the approved waiver document.
--Based on evidence presented, MPSW staff provides technical assistance, guidance and support to the operating agency staff;
--MPSW performs administrative oversight functions for OAAS HCBS programs.

Medicaid/Program Offices Quarterly Meeting – Convenes at least quarterly to perform executive level oversight of the performance of HCBS waivers, assure their effectiveness and efficiency, and discuss any other programmatic issues common to the program offices and Medicaid. Goals are to act upon issues and recommendations received from the Medicaid HCBS Oversight Committee and other HCBS workgroups. This meeting is a forum for executive level problem resolution, planning, and development of quality redesign strategies. Members include representatives from MPSW, the Medicaid Director or Deputy Director, the OAAS Assistant Secretary, and other designated staff.

MPSW/OAAS/HCBS Data Contactor Meetings– MPSW facilitates monthly meetings with OAAS and the Medicaid data contractor to discuss waiver issues, problems, and situations which have arisen and do not comport with program policy. At these meetings solutions are formulated, corrective actions are agreed upon, follow-up implemented by meeting attendees as necessary in the form of internal policy or provider policy.

Ad Hoc Cross-Population HCBS Oversight Meetings - Additional meetings will be held jointly between MPSW, OAAS, and OCDD on an as needed basis for the following purposes:

--Collaborate on design and implementation of a robust system of cross- population continuous quality improvement;
--Present Quality Improvement Projects (QIP);
--Share ongoing communication of what works, doesn't work, and best practices;and
--Work collaboratively to implement new cross-population directives or federal mandates;

Oversight specific to each Appendix A-7 function delegated to OAAS:

1. Participant waiver enrollment – BHSF maintains supervision by approving the process for entry of individuals into the waiver. Supervision of compliant entry processes occurs during the monthly MPSW/OAAS/HCBS Data Contactor Meetings.

2. Waiver enrollment managed against approved limits –The variance committee meets at least quarterly to manage waiver enrollment against approved limits. This committee is composed of representatives from OAAS, LDH's Division of Health Economics, and MPSW. This function is accomplished through the review of reports compiled by OAAS and the Division of
Health Economics using data obtained through the Medicaid data contractor and the Medicaid Management Information Systems(MMIS). These reports include the number of participants receiving services, exiting the waiver, offered a waiver opportunity,waiver closure summary, acute care utilization, and waiver expenditures. Admissions summary and level of care intake are discussed in the Medicaid Data Contractor meeting.

3. Waiver expenditures managed against approved levels– MPSW is responsible for completing the annual CMS-372 report utilizing data, submitting it to OAAS for review, and submitting to the Medicaid Director for final approval prior to submission. The variance committee meets quarterly to manage waiver expenditures against approved limits. This committee is composed of representatives from OAAS, LDH's Division of Health Economics, and MPSW. This function is accomplished through the review of reports compiled from data received through the Medicaid data contractor and MMIS. Reports include the number of participants receiving services, exiting the waiver, offered a waiver opportunity, waiver closure summary, acute care utilization, and waiver expenditures. The variance committee reviews expenditure trends and forecasts and discusses any planned or anticipated changes that could impact program expenditures.

4. Level of care evaluation – OAAS is responsible for submitting aggregated reports on level of care assurances to BHSF on an established basis as described in the Appendix B Quality Improvement Strategy (QIS) of the waiver application. OAAS formally presents level of care performance measures findings/remediation actions to MPSW via the Medicaid HCBS Oversight Committee.

5. Review participant service plans- OAAS is responsible for submitting aggregated reports on service plan assurances to BHSF on an established basis as specified in Appendix D of the waiver application. OAAS formally presents service plan performance measures findings/remediation actions to MPSW via the Medicaid HCBS Oversight Committee.

6. Prior authorization of waiver services - To ensure that payments are accurate for the services rendered OAAS monitors and oversees through the prior authorization process and the approved plan of care (POC). BHSF oversees OAAS's exercise of prior authorization activities through reports issued by the Medicaid Data Contractor and through monthly MPSW/OAAS/HCBS Data Contactor Meetings. System changes related to claims processing and prior authorization can only be facilitated by BHSF. OAAS formally presents service plan performance measure findings/remediation actions to MPSW quarterly via the Medicaid HCBS Oversight Committee as described in Appendix D: QIS sub-assurance c.

7. Utilization management – Reports are generated quarterly from the Medicaid data contractor which include: number of participants who received all types of services specified in their service plan and number of participants who received services in the amount, frequency, and duration specified in the service plan. OAAS reviews these reports for trends and patterns of under utilization
of services. OAAS formally presents service plan performance measure findings/remediation actions to MPSW quarterly via the Medicaid HCBS Oversight Committee as described in Appendix D: QIS sub-assurance d.

8. Establishment of a statewide rate methodology - BHSF determines all waiver payment amounts/rates in collaboration with OAAS, Division of Health Economics, and as necessary the BHSF Rate & Audit section. MPSW monitors adherence to the rate methodology as described in Appendix I QIS.

9. Rules, policies, procedures, and information development governing the waiver program - OAAS develops and implements written policies and procedures to operate the waiver and must obtain BHSF approval prior to any rulemaking, provider notices, waiver amendments/renewals, or policy changes.

10. Quality assurance and quality improvement activities - To ensure compliance with federal regulations governing waivers, BHSF created the Medicaid Program Support and Waivers (MPSW) Section to oversee the administration of all Louisiana Medicaid waiver programs. Monitoring is completed under the direction of the MPSW Section Chief. The MPSW Section, through performance measures listed in the Quality Improvement Strategy (QIS) and systems described in Appendix H, ensures that OAAS performs its assigned waiver operational functions including participant health and welfare assurances in accordance with this document. OAAS formally presents performance measures findings/remediation actions to MPSW quarterly via the Medicaid HCBS Oversight Committee.

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.:*

1. Medicaid Data/Prior Authorization Contractor - The Medicaid data contractor compiles and aggregates data on plans of care, such as date the initial plan is submitted and approved; date the annual POC is approved; and date the POC is received; compiles and aggregates data on support coordination, provider services, waiver slots (both occupied and vacant); compiles and aggregates information on time lines, offerings of waiver slots and linkages to support coordination agencies (SCAs); compiles and aggregates data on the waiver certification process; provides prior authorization functions; maintains the Request for Services Registry(RFSR); issues freedom of choice forms to the participant/family members to select a SCA; collects data from providers and provides various notifications to providers upon direction of OAAS or BHSF; and is responsible for Electronic Visit Verification (EVV) as required by certain CC waiver providers.

2. Long Term Care Access contractor - This contractor serves as the point of entry for individuals to request waiver services via a toll-free telephone call center. Individuals seeking waiver services contact the toll-free number in order to have their names placed on the CC Waiver Request for Services Registry (RFSR). This contractor conducts a screening on individuals who wish for their names to be placed on the CC Waiver RFSR.

3. Support Coordination Agencies (SCAs) - SCAs enrolled in Medicaid perform operational functions for level of care evaluation and re-evaluation as described in Appendix B-6.f. and for review of participant service plans as described in Appendix D-1.d.

4. Provider Enrollment/ Provider Agreements Contractor - The LDH Program Integrity Provider Enrollment (PE) unit manages the PE activities of the fiscal intermediary contractor’s PE unit. All enrollments are cleared against the Office of State Inspector General(OIG) List of Excluded Individuals/Entities (LEIE) and the System of Award Management (SAM) List of Debarred Entities and Individuals. BHSF receives monthly Program Integrity (PI) reports for aberrant billing practices and enrollment as well as ongoing reports from LDH's Health Standards Section (HSS) regarding provider licensing and certification.

○ **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

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

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 Louisiana Department of Health (LDH) Bureau of Health Services Financing (BHSF), with input from the operating agency, is responsible for assessing the performance of the data contractor, long-term care (LTC) access contractors, support coordination agencies, fiscal/employer agent, and the provider enrollment/provider agreement contractor.

Appendix A: Waiver Administration and Operation

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:

1. Medicaid Data/Prior Authorization(PA)Contractor:
The Medicaid contract monitor for the Medicaid Data/Prior Authorization Contractor reviews a monthly report tracking volume and timelines for contract activities and deliverables in the previous month. This report includes support coordination linkages, period of time between linkage and service delivery, number of new and closed support coordination linkages, and other summary statistics. The previous month's billing information is also included in the report so that report and invoice are linked together. In addition, the data contractor submits a breakdown of staff resources allocated to the contract. MPSW staff, including the contract monitor, meets monthly with contractor to review performance. The data contractor also submits data files quarterly which are reviewed and archived by the contract monitor. If there is substandard performance, MPSW will require a corrective action plan and will monitor implementation.

2. Long-Term Care (LTC) Access contractor:
OAAS conducts monitoring on this contractor by reviewing the aggregated data reports detailing their contracted duties and specific performance measures submitted at least monthly to OAAS and MPSW. Reports include administrative activities (staffing rates and staff training); monthly call volumes; screening data (number applying for various waivers and OAAS programs and screening outcomes);requestors submitted to RFSR maintained by data contractor; and updates on issues or improvements to information technology used to support contract functions. MPSW, OAAS, and the Long-Term Care Access contractor meet at least once every month to review contract work, problems, and deliverables. Invoices are not approved until monthly status reports are reviewed, approved, and all discrepancies resolved. When corrective action is needed, a corrective action plan(CAP)is required by OAAS and follow up will be conducted to evaluate the effectiveness of the CAP. Monitoring includes observation of contractor calls and processes and results in training, policy clarification, and other technical assistance and remediation as indicated. OAAS will utilize a record review audit tool to examine a random sample and to determine whether the eligibility screening process was conducted and applied appropriately.

3. Support Coordination Agencies (SCAs):
Retrospective review of Medicaid enrolled support coordinators in their performance of level of care evaluation and service plan review will occur on an annual basis through a Support Coordination Monitoring (SCM) review process performed by OAAS regional staff under the programmatic oversight of OAAS. The SCM process includes a representative sample record review with performance measures described in the Level of Care, Service Plan and Health & Welfare Quality Improvement Strategies. The results of this monitoring will be entered into a Support Coordination Monitoring database which will generate aggregate reports annually by waiver population and by SCA. Additionally, data with one hundred percent representativeness is available from the Medicaid data contractor for measures of timeliness. The results of this data will be analyzed and utilized by OAAS regional staff on a monthly basis to request and monitor corrective action based on the SCM results and enter remediation and compliance-related activities into the SCM database. The state-wide report of discovery, remediation and improvement activities for level of care and service plan review will also be analyzed and acted upon by the appropriate committees as described in appendix H-1.a.i.

4. Provider Enrollment/ Provider Agreements Contractor:
The LDH Program Integrity Provider Enrollment (PE) unit manages the PE activities of the fiscal intermediary contractor’s PE unit. All enrollments are cleared against the Office of State Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) and the System of Award Management (SAM) List of Debarred Entities and Individuals. BHSF receives monthly Program Integrity reports for aberrant billing practices and enrollment as well as ongoing reports from LDH's Health Standards Section regarding provider licensing and certification.

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.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☒	☒	☒
Waiver enrollment managed against approved limits	☒	☒	☒
Waiver expenditures managed against approved levels	☒	☒	☒
Level of care waiver eligibility evaluation	☒	☒	☒
Review of Participant service plans	☒	☒	☒
Prior authorization of waiver services	☒	☒	☒
Utilization management	☒	☒	☒
Qualified provider enrollment	☒	☐	☒
Execution of Medicaid provider agreements	☒	☐	☒
Establishment of a statewide rate methodology	☒	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☒	☐
Quality assurance and quality improvement activities	☒	☒	☐

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 the state will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver

- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:
A.a.i.3 Number and percentage of implemented QIPs that were effective as evidenced by meeting the 86% threshold upon the subsequent monitoring cycle. Numerator = Number of implemented QIPs that were effective as evidenced by meeting the 86% threshold upon the subsequent monitoring cycle; Denominator = Total number of implemented QIPs.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
A.a.i.1. Number and percentage of performance measure reports which were received on time and complete with operating agency analysis and remediation activities. Numerator = Number of performance measure reports which were received on time and complete with operating agency analysis and remediation activities; Denominator = Total number of performance measure reports due.

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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =

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

Data Aggregation and Analysis:

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

Performance Measure:
A.a.i.6. Number and percent of waiver slots certified annually that are less than or equal to the unduplicated number of participants listed in Appendix B-3-a. Numerator = Number and percent of waiver slots certified annually that are less than or equal to the unduplicated number of participants listed in Appendix B-3-a; Denominator = Total number of slots

certified.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
A.a.i.2 Number and percentage of Quality Improvement Projects (QIPs) initiated and submitted to the MPSW Section within three months of findings below the 86% threshold. Numerator = Number of Quality Improvement Projects (QIPs) initiated and submitted to the MPSW Section within three months of findings below the 86% threshold; Denominator = Total number of QIPs initiated and submitted to MPSW.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
A.a.i.4. Number and percentage of setting assessments completed where the provider was either compliant or progressing toward a plan for compliance with the HCBS Settings Rule. Numerator = Number of setting assessments completed where the provider was either compliant or progressing toward a plan for compliance with the HCBS Settings Rule; Denominator = Total number of setting assessments.

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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

A.a.i.5. Number and percentage of changes in waiver policies that were approved by BHSF

and presented for public notice prior to implementation by the operating agency. Numerator = Number of changes in waiver policies that were approved by BHSF and presented for public notice prior to implementation by the operating agency; Denominator = Total number of changes in waiver policies.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
A.a.i.7 Number and percentage of waiver offers that were appropriately made across all geographical areas to applicants on the Request for Services Registry (RFSR), according to policy and criteria set forth by the State. Numerator = Number of appropriately made offers to applicants on the RFSR; Denominator = Total number of waiver offers made.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: Medicaid Data Contractor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

A.a.i.1 – A.a.i.5

Aggregated data collected for Performance Measures A.a.i.1 – A.a.i.5 are reviewed and analyzed quarterly by via the Medicaid HCBS Oversight Committee. When remediation is indicated, the committee discusses appropriate remediation activities to resolve identified compliance issues and address systemic improvements when indicated. To achieve this end, MPSW provides technical assistance, guidance, and support to the operating agency staff. Committee minutes document remediation actions and results of these actions are presented at subsequent meetings to verify effectiveness.

The Medicaid HCBS Oversight Committee meets at least quarterly with the specific purpose to ensure proper oversight of the OAAS and OCDD operated HCBS Medicaid programs. Goals are to review current performance reports, determine

need for new activities concerning quality and oversight in waiver programs and ensure adequate remediation enforcement. Quality recommendations or issues which cannot be resolved at this level are placed on the agenda of the BHSF/Program Offices HCBS Executive Committee. Members of the Medicaid HCBS Oversight Committee include HCBS quality management staff from MPSW and OAAS and it is chaired by the MPSW Section Chief or designee.

A.a.i.6

MPSW and OAAS meet monthly with the Medicaid data contractor to discuss problems/issues identified and how to remediate. At these meetings, the members review the Daily Count of Offers, Linkages and Certifications report generated by the data contractor which includes: waiver slots available; pre-linkage, linkages to support coordinator; offers accepted; offers too recent for a response; vacancies to be offered; offers accepted and linked; recipients linked and certified; recipients linked and not certified. This report is reviewed and analyzed to determine whether the yearly maximum number of unduplicated participants certified in a waiver opportunity is nearing the limit. If the yearly maximum number of unduplicated participants certified in a waiver opportunity is approaching the limit, the state will submit a waiver amendment to CMS to modify the number of participants. Remediation of specific problems/issues/discrepancies identified are addressed in the monthly meetings and documented in the Medicaid data contractor meeting minutes (which are shared with OAAS) and the MPSW Tracking System.

A.a.i.7

MPSW and OAAS meet monthly with the Medicaid data contractor to discuss problems/issues identified and how to remediate. At these meetings, the members review the Count of Slot Types report generated by the data contractor which includes: initial allocated slots; reallocated slots due to closures; current number of allocated slots; current number of slots linked and number of remaining slots open. This report is reviewed and analyzed to identify the number of slots available for offers. OAAS and MPSW supervise whether offers are made appropriately according to established policy and criteria. If there are instances identified where offers were made inappropriately, MPSW meets with the data contractor and OAAS to address the situation and develop a plan for corrective action for resolution.
Remediation of specific problems/issues/discrepancies identified are addressed in the monthly meetings and documented in the Medicaid data contractor meeting minutes (which are shared with OAAS) and the MPSW Tracking System.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 one or more groups 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 or more waiver target groups, check each of the subgroups in the selected target group(s) 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 Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☒	**Aged**	65		☒
	☒	**Disabled (Physical)**	21	64	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

For adults with physical disabilities (age 21 - 64) in the CC Waiver. Louisiana will continue to provide waiver services to these participants whose age exceeds the maximum age limit of 64.

Initial applicants cannot meet Nursing Facility Level of Care (NFLOC) on the Behavior Pathway. Persons already receiving CC Waiver services that only meet NFLOC on the Behavior Pathway will continue to remain eligible for services until discharged from long-term care services or found eligible for services in another Medicaid program or setting more appropriate to meet their needs.

Details on all pathways of eligibility can be found in Louisiana Administrative Code (LAC) 50:II.10156 and are also included in Appendix B-6.d. as required per the CMS Technical Guide.

The seven (7) pathways of eligibility are as follows:

1. Activities of Daily Living (ADL): The intent of the ADL pathway is to determine the individual's self-care performance in ADLs during a specified look-back period. Consideration is given to what the individual actually did for himself or herself and/or how much help was required by informal supports family members or others).

2. Cognitive Performance: This pathway identifies individuals with the following cognitive difficulties:
   - short term memory which determines the individual's functional capacity to remember recent events;
   - cognitive skills for daily decision making which determines the individual's actual performance in making everyday decisions about tasks or ADLs;
   - making self-understood which determines the individual's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these (includes use of word board or keyboard).

3. Physician Involvement: The intent of this pathway is to identify individuals with unstable medical conditions that may be affecting his/her ability to care for himself/herself.

4. Treatments and Conditions Pathway: The intent of this pathway is to identify individuals with unstable medical conditions that may be affecting his/her ability to care for himself/herself.

5. Skilled Rehabilitation Therapies: The intent of this pathway is to identify individuals who have received, or are scheduled to receive, physical therapy, occupational therapy, or speech therapy (as outlined in the LAC citation above).

6. Behavior: The intent of this pathway is to identify individuals who have experienced repetitive behavioral challenges which have impacted their ability to function in the community during the specified look-back period. This pathway is being eliminated for new applicants. However, those participants already receiving waiver services who, in the past, only met nursing facility level of care on the behavior pathway will continue to remain eligible for services until discharged from long term-care services or found eligible for services in another Medicaid program or setting more appropriate to their needs.

7. Service Dependency: The intent of this pathway is to identify individuals who are currently in a nursing facility or have been receiving services continuously, since 12/01/06 or earlier, and ongoing services are required in order for the individual to maintain current functional status.

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:

Once participants in the "disabled (physical)" target subgroup (age 21-64) reach the maximum age limit, they will continue to receive services under the "aged" target subgroup which has no maximum age limit.

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)

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

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

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

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	7908
Year 2	9381
Year 3	9381
Year 4	9381
Year 5	9381

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	6553
Year 2	8053
Year 3	8053
Year 4	8053
Year 5	8053

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).**

Purpose(s) the state reserves capacity for:

Purposes	
Reserved for Persons Diagnosed with ALS	
Expedited Community Choices Waiver Opportunities	

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

Reserved for Persons Diagnosed with ALS

Purpose *(describe):*

The state reserves 75 CC Waiver slots for persons diagnosed with ALS.

Describe how the amount of reserved capacity was determined:

The state reserved 75 slots for persons diagnosed with ALS. This set aside was authorized by the Louisiana Legislature during the 2007 Regular Legislative Session.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	75
Year 2	75
Year 3	75
Year 4	75
Year 5	75

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

Expedited Community Choices Waiver Opportunities

Purpose *(describe):*

Up to 300 Community Choices (CC) Waiver opportunities may be granted to qualified individuals who require expedited waiver services. These individuals shall be offered an opportunity on a first-come, first-served basis. To be considered for an expedited waiver opportunity, the individual must, at the time of the request for the expedited opportunity, be approved for the maximum amount of Long Term-Personal Care Services (LT-PCS) and require institutional placement, unless offered an expedited waiver opportunity. The following criteria shall be considered in determining whether or not to grant an expedited waiver opportunity:

a. Support through other programs is either unavailable or inadequate to prevent nursing facility placement;
b. The death or incapacitation of an informal caregiver leaves the person without other supports;
c. The support from an informal caregiver is not available due to a family crisis,
d. The person lives alone and has no access to informal support; or
e. For other reasons, the person lacks access to adequate informal support to prevent nursing facility placement.

Describe how the amount of reserved capacity was determined:

The number of reserved capacity expedited CC Waiver opportunities was based on requirements set forth in the Pitts v. Greenstein Settlement Agreement (January 2012).

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	300
Year 2	300
Year 3	300
Year 4	300
Year 5	300

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:

LDH is responsible for the CC Waiver Request for Services Registry (RFSR). Individuals who wish for their name to be placed on the CC Waiver RFSR shall contact the toll-free telephone number maintained by the Long Term Care Access contractor.

CC Waiver opportunities shall be offered to individuals on the RFSR pursuant to priority groups. The following groups shall have priority for CC Waiver opportunities, in the order listed:

1) Individuals with substantiated cases of abuse or neglect referred by Protective Services who, without Community Choices Waiver services, would require institutional placement to prevent further abuse and neglect;
2) Individuals diagnosed with Amyotrophic Lateral Sclerosis (ALS);
3) Individuals who are residing in a State of Louisiana Permanent Supportive Housing unit or who are linked for the State of Louisiana Permanent Supportive Housing selection process;
4) Individuals admitted to, or residing in, a nursing facility who have Medicaid as the sole payer source for the nursing facility stay, with the intent that they be discharged to the community;
5) Individuals who require expedited waiver services who are approved for the maximum amount of services allowable under LT-PCS and will require institutional placement, unless offered an expedited waiver opportunity;
6) Individuals who are not presently receiving home and community based services (HCBS) under another Medicaid program, including, but not limited to: Program of All-inclusive Care for the Elderly (PACE), Long Term - Personal Care Services (LT-PCS), and/or any other 1915(c) waiver.

All other eligible individuals on the RFSR will be offered a CC Waiver opportunity according to the date of first request for services.

If an applicant is determined to be ineligible for any reason, the next individual on the RFSF is notified as stated above and the process shall continue until an individual is determined eligible. A CC Waiver opportunity is assigned to an individual when eligibility is established and the individual is certified.

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)*:

- (●) **Section 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)

- [ ] **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- [ ] **Pregnant Women (42 CFR § 435.116)**
- [ ] **Infants and Children under Age 19 (42 CFR § 435.118)**

☒ **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 section 1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 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 section 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 section 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:

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*

○ **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 spend down 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 assets 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 7)

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. 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:

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under section 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 uses *spousal* post-eligibility rules under section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under section 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 section 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 (Section 1634 State/SSI Criteria 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 section 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 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

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:

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 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

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 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 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 section 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-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules at 42 CFR § 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in section 1924 of the Act. 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:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in section 1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **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 (6 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State – January 1, 2014 through September 30, 2027 (or other date as required by law).

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 (7 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules of section 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. 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).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

Specify percentage:

- ○ **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 formula:

○ **Other**

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR § 435.726 or 42 CFR § 435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726 or 42 CFR § 435.735:

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 uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

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: 2

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:

Support Coordination Agencies enrolled with Medicaid and certified by OAAS.

OAAS Regional Offices (ROs) may assist SCAs with completing level of care evaluations and re-evaluations upon SCA request or as deemed necessary by OAAS. RO office staff completing all evaluations/re-evaluations meet all qualifications prior to performing these activities. In addition, any level of care evaluations and re-evaluations conducted are subject to review according to the State's existing annual SCA monitoring procedures.

- ( ) **Other**

Specify:

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:

Individuals performing the initial level of care evaluation must have the following qualifications:

- Bachelor's or Master's degree in social work from a program accredited by the Council on Social Work Education; or-

- Bachelor's or Master's degree in nursing (RN) currently licensed in Louisiana (one year of paid experience will substitute for the degree);or

- Bachelor's or Master's degree in a human service related field which includes: psychology, education, counseling, social services, sociology, philosophy, family and participant sciences, criminal justice, rehab services, substance abuse, gerontology, and vocational rehabilitation;

- Bachelor’s degree in liberal arts or general studies with a concentration of at least 16 hours in one of the fields listed above in the human service related field; or

- Bachelor's or Master's degree in a field other than listed above, if approved by OAAS.

All individuals who make level of care evaluations must also be trained and certified by LDH.

There is no differentiation between who can and cannot conduct initial and subsequent evaluations.

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.

Applicants and participants are evaluated/re-evaluated using an interRAI assessment tool designed to determine if a participant meets/continues to meet Level of Care (LOC) by assessing multiple key domains of function, health, social support and service use. The following seven (7) factors or "pathways of eligibility", (also specified in Louisiana Administrative Code-LAC 50:II.10156) are:

• Activities of Daily Living (ADL): The intent of the Activities of Daily Living (ADL) pathway is to determine the individual's self-care performance in Activities of Daily Living during a specified look-back period. Consideration is given to what the individual actually did for himself or herself and/or how much help was required by family members or others.

• Cognitive Performance: This pathway identifies individuals with the following cognitive difficulties:

o short term memory which determines the individual's functional capacity to remember recent events;

o cognitive skills for daily decision making which determines the individual's actual performance in making everyday decisions about tasks or Activities of Daily Living;

o making self understood which determines the individual's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these (includes use of word board or keyboard).

• Physician Involvement: The intent of this pathway is to identify individuals with unstable medical conditions that may be affecting his/her ability to care for himself/herself.

• Treatments and Conditions Pathway: The intent of this pathway is to identify individuals with unstable medical conditions that may be affecting his/her ability to care for himself/herself.

• Skilled Rehabilitation Therapies: The intent of this pathway is to identify individuals who have received, or are scheduled to receive, physical therapy, occupational therapy, or speech therapy (as outlined in the LAC citation above).

• Service Dependency: The intent of this pathway is to identify individuals who are currently in a nursing facility or have been receiving services continuously since 12/01/06 or earlier, and ongoing services are required in order for the individual to maintain current functional status.

• Behavior: The intent of this pathway was to identify individuals who experienced repetitive behavioral challenges which impacted his/her ability to function in the community during the specified look-back period. This pathway is being eliminated. However, those individuals already receiving waiver services who, in the past, only met nursing facility level of care on the Behavior Pathway will continue to remain eligible for services until the individual is discharged from long term care services, or the individual has been found eligible for services in another program or setting more appropriate to their needs.

Following completion of the interRAI assessment conducted by an OAAS certified assessor, the results are entered into a software system which uses algorithms to identify factors which would qualify an individual as having met Level of Care on any of the pathways listed above. A review of the final results is also conducted by the OAAS certified assessor and that assessor's supervisor to ensure accuracy of the final determination.

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.

Different instruments are used to determine level of care for the waiver and level of care for institutional services, however both instruments use the same criteria and a common sub-set of questions to determine if level of care is met. Both tools are derived from the interRAI suite of assessment tools developed by the interRAI research group.

Louisiana worked with interRAI members from the University of Michigan to develop a level of care tool called the LOCET that is used to determine if applicants meet level of care for institutional care. LOCET is derived from the Minimum Data Set 3.0 (for Nursing Facilities)- MDS 3.0 and uses a subset of questions and algorithms from that comprehensive assessment instrument to determine that level of care is met.

For waiver services, the instrument used to determine level of care is the interRAI home care assessment tool, a sister-tool to the MDS 3.0 which includes not only the nursing facility level of care questions, but is also designed to gather comprehensive assessment information needed to develop care plans for waiver participants. For these reasons, this interRAI assessment tool is used as the tool for determining nursing facility level of care for home and community-based services applicants. The criteria which trigger nursing facility level of care are the same as on the LOCET. (These criteria are noted in item B-6-d).

The interRAI assessment tool is used for collection of assessment information relative to waiver initial evaluation (level of care determination of eligibility). This tool is designed for use by non-clinicians. It was developed by the interRAI group after years of study of populations similar to those in the Louisiana waiver programs. No medical background is needed for an assessor to be qualified to conduct the assessment. OAAS requires that the support coordinator who conducts the assessment be trained and certified by OAAS before conducting these assessments.

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:

Initial Level of Care Evaluation:

Once the individual receives a waiver offer and is linked to the Support Coordination Agency (SCA) that they selected, OAAS or its designee, or the Support Coordinator (SC) completes the assessment during a face-to-face assessment visit which is usually conducted in the individual's home but which may be conducted in another location of the applicant's choosing. The SC must complete the face-to-face assessment within ten (10) business days following the linkage. Information collected via the interRAI home care assessment is entered into a computer program which uses programmed algorithms, described in B-6-d, to determine if an applicant has met level of care. If level of care is met, the SC proceeds in developing a plan of care (POC) based on the totality of the assessment. If level of care is not met, the OAAS Regional Office (RO) reviews the assessment and level of care results to make a final level of care determination. RO review may also include a home visit to the applicant and completion of a new assessment.

The data contractor releases Prior Authorizations (PAs) for support coordination/Initial Plan of Care Development if initial tasks are completed and entered into the electronic system in a timely manner.

Re-evaluations:

The process for level of care re-evaluation is the same as for initial level of care evaluation. (Refer to section B.6.i. for the annual re-evaluation timelines.)

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:

Re-evaluation of level of care is conducted no less than every 12 months or when there is a change in the individual's status that requires a re-assessment.

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):*

Timeliness of level of care re-evaluations is monitored and ensured via an electronic system provided by the data contractor.

The data contractor releases Prior Authorizations (PAs) for support coordination only if all required tasks (monthly, quarterly, and annual) are completed and entered into the electronic system in a timely manner.

Support Coordination Agency (SCA) supervisors have access to an electronic tickler generated from the system indicating when POCs are going to expire. OAAS ROs access a comparable report provided by the data contractor. This allows all parties to monitor timeliness of reevaluation.

Documentation of LOC re-evaluation which is included in the approved Plan of Care (POC) packet must be submitted by the SC Supervisor to the data contractor and/or RO within 14-90 days prior to the expiration date.

The SC Supervisor submits documentation of the SC Supervisor LOC/POC approval to the data contractor. The data contractor enters the SC supervisor LOC/POC submittal date into the prior authorization database.

If the submittal of the SC supervisory LOC/POC approval is less than 14 days from expiration date, the PA for SC services is not released for a minimum of one month.

If review of reports from the data contractor indicate ongoing failure to perform reevaluations within required time frames, RO will follow up with the SCA for purposes of remediation as described in Appendix B Quality Improvement b. Methods for Remediation/Fixing Individual Problems.

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:

Level of care records are available on an assessment and level of care database maintained by OAAS and the SMA has access to these records at all times. Records of evaluations and reevaluations are maintained for a minimum of 6 years.

Comprehensive assessment information is made available to all members of the planning team where it is deemed necessary.

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

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

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

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

Performance Measure:
B.a.i.a.1. Number and percent of new enrollees who had a level of care indicating need for institutional level of care prior to receipt of services. Numerator = Number of new enrollees who had a level of care indicating need for institutional level of care prior to receipt of services; Denominator = Total number of new enrollees.

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

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **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 the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

c. ***Sub-assurance: The 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 the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
B.a.i.c.2 Number and percent of participants whose LOC determinations were made by a qualified evaluator. Numerator = Number of participants whose LOC determinations were made by a qualified evaluator; Denominator = Total number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
B.a.i.c.1. Number and percent of participants whose initial and annual LOC determinations forms/instruments were completed as required by the state. Numerator = Number of participants whose initial and annual LOC determinations forms/instruments that were completed as required by the state; Denominator = Total number of participants reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% + or -5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Regarding B.a.i.c.1 and B.a.i.c.2, OAAS Regional Office (RO) staff conduct monitoring of Support Coordination Agencies (SCAs) at least annually utilizing the OAAS Support Coordination Monitoring Tools: Participant Interview, Participant Record Review, Support Coordinator Interview, and Agency Review. The sample size will be large enough for a confidence level of 95% and will be generated on the first day of each waiver year. The number of participants from the statewide sample to be included in each SCA sample will be proportional to the percentage of participants linked to each agency on the first day of each waiver year. A SCA's sample size will be determined separately for each region in which the SCA operates.

Regarding B.a.i.c.2, OAAS reviewers will identify through record review the Support Coordinator (SC) who performed the LOC evaluation. The OAAS reviewer will then check the training database to determine if the LOC evaluator received certification from OAAS.

Discrepancies or inaccuracies detected during the record review are corrected upon discovery.

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The State's method for addressing individual problems identified through performance measure B.a.i.a.1 is as follows:

OAAS State Office receives quarterly reports from the data contractor for review. If LOC discrepancies are identified, State Office will contact the RO to contact the SCA. The SCA will have 10 days to correct the discrepancies. Depending upon the frequency and persistence of such problems, OAAS may pursue sanctions as outlined in the Support Coordination Performance Agreement. The remediation activities will be documented in a spreadsheet by RO.

The State's method for addressing individual problems identified through performance measures B.a.i.c.1 and B.a.i.c.2. are as follows:

RO staff perform monitoring of SCAs at least annually utilizing the OAAS Support Coordination Monitoring Tools: Participant Interview; Participant Record Review; Support Coordinator Interview; and Agency Review. The processes for scoring and determining the necessity for corrective actions are located in the SCA Monitoring Policy and Procedures Manual. After all elements are assessed and scored, RO reviewer documents the findings, including the Statement of Determination which delineates every remediation required within the LOC/POC and required responses/corrective action plans required from the SCA. Based on the scope and severity of findings, the SCA is assigned a Statement of Determination at Level I, Level II, or Level III. OAAS RO and/or State Office follow-up according to timelines associated with each level to ensure that corrective action plans are implemented and effective. If a corrective action plan, progress report and/or follow-up report remain unapproved by the time of the next annual review the agency placed on the next level with more stringent requirements. With a finding of satisfactory or a recommendation for improvement no remediation is required. These remediation activities will be documented through tracking events in the Support Coordination Monitoring database.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 Louisiana Department of Health (LDH) Long Term Care Access contractor gives individuals and/or their responsible representative the choice of either institutional or home and community-based services and verbally informs them of their alternatives at the time an individual first requests long term care services. Individuals are given the option to choose between institutional or home and community-based services in writing and are informed of their alternatives under the waiver at the time they are going through the Medicaid application and determination process. These options are also sent by the data contractor at the time of the waiver offer is made and the choice is explained by the Support Coordinator (SC). The Long Term Care Program Choice Decision form, Support Coordination Choice/Release of Information form and Community Choices Provider (CC) Choice/Release of Information form are all used to document freedom of choice.

When the initial waiver offer is made, the data contractor mails the offer with the Support Coordination Agency (SCA) selection form. If the data contractor does not receive the SCA selection form within two (2) weeks, the SCA selection form is re-sent. If in another two (2) weeks a selection of an SCA has not been made by the waiver participant, the data contractor auto-selects an SCA. The SC discusses the availability of all services in the waiver(including support coordination)and reviews the OAAS Rights and Responsibilities document at their initial and annual recertification visits. On the OAAS Rights and Responsibilities document, it states that participants may change support coordination agencies every six (6) months; or at any time with "good cause". The auto-selection process is designed to ensure participants are equally assigned among all available SCAs. It is at the participant's discretion to select another SCA if they are not satisfied with the choice. The waiver participant will attest that FOC of all service providers was given by his/her signature on the POC.

At initial and upon annual recertification of the participant, the SC discusses the availability of all services in the waiver and the direct service provider freedom of choice form. The direct service provider freedom of choice lists names of local providers enrolled in Medicaid and this listing is available on the OAAS website. The list of providers on the website is current and is maintained by OAAS.

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.

Forms are maintained by OAAS Regional Offices, the data contractor, and/or the SCA.

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):

A language service vendor is under contract with LDH. Additionally, Support Coordination Agencies (SCAs) must utilize a language service vendor, if needed for a Limited English Proficient (LEP) waiver participant.

All BHSF application forms are published in English, Spanish, and Vietnamese and are available in alternative format upon request.

Alternative methods of communication are used as the situation arises. Language services for LEP are provided in two (2) main ways: oral and written language services (interpretation and translation, respectively). Both offer substantial flexibility in determining the appropriate mix and medium.

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	Adult Day Health Care		
Statutory Service	Caregiver Temporary Support Service		
Statutory Service	Support Coordination		
Supports for Participant Direction	Financial Management Services		
Other Service	Assistive Devices and Medical Supplies		
Other Service	Assistive Technology		
Other Service	Environmental Accessibility Adaptation		
Other Service	Home Delivered Meals		
Other Service	Housing Stabilization Services		
Other Service	Housing Transition or Crisis Intervention Services		
Other Service	Monitored In-Home Caregiving		
Other Service	Nursing		
Other Service	Personal Assistance Services (PAS)		
Other Service	Skilled Maintenance Therapy		
Other Service	Transition Intensive Support Coordination		
Other Service	Transition Service		

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:

Adult Day Health

Alternate Service Title (if any):

Adult Day Health Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04050 adult day health
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services furnished as specified in the plan of care at an ADHC center, in a non-institutional, community-based setting

encompassing both health/medical and social services needed to ensure the optimal functioning of the participant. All ADHCs shall be compliant with the HCBS Settings Rule and will incorporate appropriate non-residential qualities of a home and community-based setting as described in 42 CFR §441.301(c)(4)(5).

Adult Day Health Care (ADHC) Services include:

- One nutritionally-balanced hot meal and a minimum of two snacks served each day;
- Transportation between the participant's place of residence and the ADHC center, in accordance with licensing standards;
- Assistance with activities of daily living;
- Health and nutrition counseling;
- Individualized daily exercise program;
- Individualized goal-directed recreation program;
- Daily health education;
- Medical care management;
- Transportation to and from medical and social activities if the participant is accompanied by the ADHC center staff; and
- Individualized health/nursing services.

Nurses are involved in the participant’s service delivery, as specified in the plan of care or as needed. Each participant has a Plan of
Care (POC) from which the ADHC provider develops an individualized service plan. If the individualized service plan calls for certain
health and nursing services, the nurse on staff ensures that said services are delivered while the participant is at the ADHC center.

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

Services are furnished on a regularly scheduled basis, not to exceed 10 hours a day and no more than 50 hours per week.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Adult Day Health Care

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health Care

Provider Category:

Agency

Provider Type:

Adult Day Health Care

Provider Qualifications

License *(specify):*

Must be licensed according to the Louisiana Revised Statutes (R.S. 40:2120.41 through 2120.47).

Certificate *(specify):*

Other Standard *(specify):*

Must be enrolled as an ADHC Medicaid provider, except for those providers who choose to sub-contract with an OHCDS that is an enrolled Medicaid provider

Qualifications for ADHC center staff are set forth in the Louisiana Administrative Code (LAC).

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Standards Section

Frequency of Verification:

Initial and as deemed 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:

Respite

Alternate Service Title (if any):

Caregiver Temporary Support Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Caregiver Temporary Support Services are furnished on a short-term basis because of the absence or need for relief of caregivers during the time they are normally providing unpaid care for the participant. Federal Financial participation is not

claimed for the cost of room and board except when provided as part of Caregiver Temporary Support Services furnished in a facility approved by the State that is not a private residence. The intent of Caregiver Temporary Support Services is to provide relief to unpaid caregivers to maintain the informal support system.

Caregiver Temporary Support Services are provided in the participant's home or place of residence or in the following locations:

- Nursing Facilities;
- Assisted Living Facilities/Adult Residential Care Facilities;
- Respite Centers; and
- Adult Day Health Care centers.

Caregiver Temporary Support Services may be provided for the relief of the principal caregiver for participants who receive Monitored In-Home Caregiving services.

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

Caregiver Temporary support services may be utilized no more than 30 days or 29 overnight stays per Plan of Care (POC) year for no more than 14 consecutive calendar days or 13 consecutive overnight stays. The service limit may be increased based on documented need and prior approval by OAAS.

Caregiver temporary support services provided by nursing facilities, assisted living facilities and respite centers must include an overnight stay.

When Caregiver temporary support service is provided by an ADHC center, services may be provided no more than 10 hours per day.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Nursing Facility (Out of Home Respite)
Agency	Respite Center (Out of Home Respite)
Agency	Assisted Living Facility/Adult Residential Care Facility to Assisted Living (Out of Home Respite)
Agency	Home Health (In Home Respite)
Agency	Adult Day Health Care (Out of Home Respite)
Agency	Personal Care Attendant (In Home Respite)

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Caregiver Temporary Support Service

Provider Category:

Agency

Provider Type:

Nursing Facility (Out of Home Respite)

Provider Qualifications

License *(specify):*

Must be licensed according to the Louisiana Revised Statutes (R.S. 40:2009.1).

Certificate *(specify):*

Other Standard *(specify):*

Must be enrolled as a Medicaid Caregiver Temporary Supports provider, except for those providers who choose to sub-contract with an OHCDS that is an enrolled Medicaid provider.

Must comply with all LDH rules and regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Standards Section

Frequency of Verification:

Initial and as deemed necessary

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Caregiver Temporary Support Service

Provider Category:

Agency

Provider Type:

Respite Center (Out of Home Respite)

Provider Qualifications

License *(specify):*

Must be licensed according to the Louisiana Revised Statutes (R.S. 40:2120.1).

Certificate *(specify):*

Other Standard *(specify):*

Must be enrolled as a Medicaid Caregiver Temporary Supports provider, except for those providers who choose to sub-contract with an OHCDS that is an enrolled Medicaid provider

Must comply with LDH rules and regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Standards Section

Frequency of Verification:

Initial and as deemed necessary

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Caregiver Temporary Support Service

Provider Category:

Agency

Provider Type:

Assisted Living Facility/Adult Residential Care Facility to Assisted Living (Out of Home Respite)

Provider Qualifications

License *(specify):*

Must be licensed according to the Louisiana Revised Statutes (R.S. 40:2166.1).

Certificate *(specify):*

Other Standard *(specify):*

Must be enrolled as Medicaid Caregiver Temporary Support provider, except for those providers who choose to sub-contract with an OHCDS that is an enrolled Medicaid provider.

Must comply with all LDH rules and regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Standards Section

Frequency of Verification:

Initial and as deemed necessary

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Caregiver Temporary Support Service

Provider Category:

Agency

Provider Type:

Home Health (In Home Respite)

Provider Qualifications

License *(specify):*

Must be licensed according to the Louisiana Revised Statutes (R.S. 40:2116.31).

Certificate *(specify):*

Other Standard *(specify):*

Must be enrolled as a Medicaid Caregiver Temporary Support provider, except for those providers who choose to sub-contract with an OHCDS that is an enrolled Medicaid provider.

Must comply with all LDH rules and regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Standards Section

Frequency of Verification:

Initial and as deemed necessary

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Caregiver Temporary Support Service

Provider Category:

Agency

Provider Type:

Adult Day Health Care (Out of Home Respite)

Provider Qualifications

License *(specify):*

Must be licensed according to the Louisiana Revised Statutes (R.S. 40:2120.41 through 2120.47).

Certificate *(specify):*

Other Standard *(specify):*

Must be enrolled as a Medicaid Caregiver Temporary Supports provider, except for those providers who choose to sub-contract with an OHCDS that is an enrolled Medicaid provider

Must comply with all LDH rules and regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Standards Section

Frequency of Verification:

Initial and as deemed necessary

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Caregiver Temporary Support Service

Provider Category:

Agency

Provider Type:

Personal Care Attendant (In Home Respite)

Provider Qualifications

License *(specify):*

Must be licensed according to the Louisiana Revised Statutes (R.S. 40:2120.1).

Certificate *(specify):*

Other Standard *(specify):*

Must be enrolled as a Medicaid direct service provider, except for those providers who choose to sub-contract with an OHCDS that is an enrolled Medicaid provider.

Must comply with LDH rules and regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Standards Section

Frequency of Verification:

Initial and as deemed 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:

Case Management

Alternate Service Title (if any):

Support Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Support Coordination services assist participants in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational, housing, and other non-Medicaid services. Support Coordination Agencies shall be required to perform the following core elements of support coordination:

*Intake;
*Assessment/Re-assessment;
*Plan of care development and revision;
*Linkage to direct services and other resources;

*Coordination of multiple services among multiple providers;
*Monitoring(regular, at least monthly)/follow-up;
*Evaluation and re-evaluation of level of care and need for waiver services;
*Ongoing assessment and mitigation of health, behavioral and personal safety risk;
*Responding to participant crises;
*Critical incident management; and
*Transition/discharge and closure.

This service is available to participants during a waiver participant's temporary stay in a nursing facility or hospital.

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

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**
☐ **Remote/via Telehealth**

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	Support Coordination Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Support Coordination

Provider Category:

Agency

Provider Type:

Support Coordination Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified as a case management (support coordination) agency by LDH/OAAS.

Other Standard *(specify):*

Must enroll as a Medicaid support coordination agency provider.

Must sign and comply with OAAS SCA Performance Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Aging and Adult Services

Frequency of Verification:

Initial and annual

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:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-dir
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Financial Management Services (FMS) are provided by a Medicaid enrolled Fiscal Employer Agency. The Fiscal Employer Agency (FEA) is the fiscal agent that assures financial accountability for self-direction services.

FMS is provided to participants who have chosen and are capable of self-directing his/her waiver services. FMS assists the participant to live independently in the community while controlling his/her services by choosing the staff who work with him/her. FMS must be included and prior authorized in his/her approved plan of care prior to participation in self-direction.

The FEA is to assist participants and direct support workers in enrolling with the FEA provider and training participants and staff regarding self-direction activities and processes. The FEA provider is to assist the participant in understanding billing and documentation requirements. The FMS provider must ensure a state approved EVV system is successfully in place and operational prior to services being initiated.

The FEA provider is to perform the employer responsibilities of payroll processing which includes: issuance of paychecks; withholding federal, state and local tax and making tax payments to the appropriate tax authorities; issuance of W-2 forms; and meeting worker’s compensation insurance requirements. The FEA provider is responsible for performing all fiscal

accounting procedures including issuance of expenditure reports to the member, his/her representative, Louisiana Department of Health. The FEA provider must maintain a separate account for each participant while continually tracking and monthly reporting of funds, disbursements and the balance of the participant's service units. The FEA provider must have customer service available in order to assist participants and direct support workers with complaints/issues and to address questions regarding self-direction. The FEA provider must comply with all requirements included in the Fiscal Employer Agency Readiness Review and Performance Agreement.

Participant responsibilities include functioning as the employer for his/her direct support worker(s) or designate a representative to manage/assist with management of direct support workers; hire direct support workers and refer them to the FEA provider for completion of enrollment requirements; establish the wage/rate of pay for each direct support worker; provide or arrange for appropriate orientation and training of direct support workers; determine direct support worker schedules, determine tasks to be performed as indicated in the plan of care; manage and supervise the day-to-day work activities of the direct support staff, verify time worked by direct support workers and that services were delivered in accordance to his/her plan of care, assure utilization of the EVV system to capture the time worked by each direct support worker, and other documentation required by the state and by CMS (The EVV system will indicate the actual hours worked in accordance with his/her approved plan of care); completion of required documents needed by the FEA for processing and payment in accordance with established FEA, State, and Federal requirements; report work-related injuries incurred by the DSW(s) to the FEA provider; develop an emergency plan and a worker back-up plan; assure all appropriate service documentation is recorded as required by the State; inform the FEA of any changes in the status of direct support workers, including, but not limited to changes of address or telephone number inform the FEA of the dismissal of a direct support worker inform the FEA of any changes in the status of the participant or participant's representative, such as the participant's address, telephone number, email address within three (3) working days; participate in required quality assurance visits/oversight with the participant's support coordinator, or other Federal and State authorized reviewers/auditors.

Payment for FMS will be reimbursed via a monthly PMPM rate.

This service is not duplicative with other waiver services.

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

Each participant is limited to one unit of FMS a month.

Financial Management Services must be prior authorized.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Fiscal Employer Agent

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

Provider Category:

Agency

Provider Type:

Fiscal Employer Agent

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must pass a readiness review and sign a performance agreement prior to enrolling as a Medicaid provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid/MPSW

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:

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:

Assistive Devices and Medical Supplies

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 3:	**Sub-Category 3:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 4:	**Sub-Category 4:**
17 Other Services	17010 goods and services

Service Definition *(Scope):*

Assistive devices and medical supplies are specialized medical equipment and supplies which includes:
- Devices, controls, appliances or nutritional supplements specified in the plan of care that enable participants to increase their ability to perform Activities of Daily Living (ADLs);
- Devices, controls, appliances or nutritional supplements that enable participants to perceive, control or communicate with the environment in which they live or provide emergency response;
- Items, supplies and services necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items;
- Supplies and services to assure participants' health and welfare;
- Other durable and non-durable medical equipment and necessary medical supplies that are necessary but not available under the State plan;
- Personal Emergency Response Systems (PERS);
- Other in-home monitoring and medication management devices and technology;
- Routine maintenance or repair of specialized equipment; and
- Batteries, extended warranties, and service contracts that are cost effective and assure health and welfare.

This includes medical equipment not available under the State Plan that is necessary to address participant functional limitations and necessary medical supplies not available under the State Plan that are addressed in the Plan of Care (POC) or other supporting documentation.

This service is available to participants during transition from a nursing facility to the community and during a waiver participant's temporary stay in a nursing facility or hospital.

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

Where applicable, participant must use Medicaid state plan, Medicare, or other available payers first. The participant's preference for a certain brand or supplier is not grounds for declining another payer in order to access waiver services.

All services must be based on a verified need of the participant and the service must have a direct or remedial benefit to the participant with specific goals and outcomes. This benefit must be determined by an independent assessment on any items whose cost exceeds $500 and on all communication devices, mobility devices, and environmental controls. Independent assessments are performed by individuals who have no fiduciary relationship with the manufacturer, supplier, or vendor of the item.

All services must reduce reliance on other Medicaid State Plan or waiver services.

All items meet applicable standards of manufacture, design, and installation.

Items must be on the POC developed by the support coordinator subject to regional office approval.

All items must be pre-approved.

No experimental items.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Support Coordination Agency

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Durable Medical Equipment
Agency	Assistive Devices
Agency	Personal Emergency Response System (PERS)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Devices and Medical Supplies

Provider Category:

Agency

Provider Type:

Support Coordination Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified as a case management (support coordination) agency by LDH/OAAS.

Other Standard *(specify):*

Must enroll as a Medicaid support coordination agency provider.

Must sign and comply with OAAS SCA Performance Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

OAAS

Frequency of Verification:

Initial and annual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Devices and Medical Supplies

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Must be licensed according to the Louisiana Revised Statutes (R.S. 40:2116.31).

Certificate *(specify):*

Other Standard *(specify):*

Must enroll as a Medicaid Assistive Devices provider, except for those providers who choose to sub-contract with an OHCDS that is an enrolled Medicaid provider.

Must comply with all LDH rules and regulations.

Must sign OAAS provider attestation form.

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Provider Enrollment

Frequency of Verification:

Initial

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Devices and Medical Supplies

Provider Category:

Agency

Provider Type:

Durable Medical Equipment

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must enroll as a Medicaid Assistive Devices provider, except for those providers who choose to sub-contract with an OHCDS that is an enrolled Medicaid provider.

Must comply with all LDH rules and regulations.

Must sign OAAS provider attestation form.

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Provider Enrollment

Frequency of Verification:

Initial

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Devices and Medical Supplies

Provider Category:

Agency

Provider Type:

Assistive Devices

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must enrolled as a Medicaid Assistive Devices provider, except for those providers who choose to sub-contract with an OHCDS that is an enrolled Medicaid provider.

Must comply with all LDH rules and regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Provider Enrollment

Frequency of Verification:

Initial

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Devices and Medical Supplies

Provider Category:

Agency

Provider Type:

Personal Emergency Response System (PERS)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must enroll as a Medicaid Personal Emergency Response System provider,except for those providers who choose to sub-contract with an OHCDS that is an enrolled Medicaid provider.

Must comply with all LDH rules and regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Provider Enrollment

Frequency of Verification:

Initial

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:

Assistive Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Assistive Technology services are time limited, non-recurring and include the following:

- an electronic tablet device with internet capability, acquired commercially, that is used to increase, maintain or improve functional capabilities of participants.

- a screen protector and/or a case for the device to protect the item from damage.

- the assistance provided to the participant in the acquisition, set up and use of an assistive technology device.

a. Evaluating to determine if an assistive technology device is appropriate for the participant.
b. Purchasing the most appropriate assistive technology device, including protective item(s) for the device, for the participant.
c. Costs associated with the delivery, set up and training.

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

One-time lifetime $300 maximum per individual ($250 maximum for the device, screen protector and/or case & $50 maximum for the set up visit).

Assistive Technology services are included as part of the State's approved HCBS Spending Plan authorized under Section 9817 of the ARPA through March 31, 2025 or until the State's authorized funding is exhausted.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

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	Support Coordination Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Support Coordination Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified as a case management (support coordination) agency by LDH/OAAS.

Other Standard *(specify):*

Must enroll as a Medicaid Support Coordination Agency provider.

Must sign and comply with OAAS SCA Performance Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Aging and Adult Services (OAAS).

Frequency of Verification:

Initial and annual

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:

Environmental Accessibility Adaptation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Necessary physical adaptations/modifications that will be made to the home to reasonably assure the health and welfare of the participant, or enable the participant to function with greater independence in the home. Without these necessary adaptations/modifications, the participant would require institutionalization.

There must be an identified need for environmental accessibility adaptations/modifications as indicated by the assessment or supporting documentation of the need.

Once identified, a credentialed EAA assessor must verify the need for and draft specifications for the Environmental Accessibility Adaptation(s) (EAA).

A credentialed EAA assessor must ensure that the EAA meets all specifications before payment shall be made to the EAA contractor that performed the modifications/EAA(s).

Home adaptations/modifications include the following:
- Ramps
- Lifts (porch, stair, hydraulic, manual, and other electronic lift)
- Modifications to bathroom facilities (roll-shower, sink, bathtub, toilet, water faucet control, and plumbing)
- Additions/modifications to bathroom facilities (roll-shower, water faucet control, floor urinal, bidet, and turnaround space)
- Specialized accessibility/safety adaptations/additions/modifications (door widening, electrical wiring, grab bar, handrail, automatic door opener/doorbell, voice activated/light activated/motion activated/electronic device, fire safety adaptation, medically necessary air filtering device, medically necessary heating/cooling adaptation, and other modifications to the home necessary for medical or personal safety).

This service cannot be used for basic home construction and repairs.

This service is available to participants during transition from a nursing facility to the community and during a waiver participant's temporary stay in a nursing facility or hospital.

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

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

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	Environmental Accessibility Adaptation - Contractor
Agency	Environmental Accessibility Adaptation - Assessor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptation

Provider Category:

Agency

Provider Type:

Environmental Accessibility Adaptation - Contractor

Provider Qualifications

License *(specify):*

Must meet all state and/or local requirements (such as building contractors, plumbers, electricians, or engineers).

Certificate *(specify):*

Must meet all state and/or local requirements (such as building contractors, plumbers, electricians, or engineers).

Other Standard *(specify):*

Must enroll as a Medicaid Environmental Accessibility Adaptation contractor,except for those providers who choose to sub-contract with an OHCDS that is an enrolled Medicaid provider.

Must sign OAAS Provider Attestation form.

Must comply with all LDH rules and regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Aging and Adult Services (OAAS)

Frequency of Verification:

Initial

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptation

Provider Category:

Agency

Provider Type:

Environmental Accessibility Adaptation - Assessor

Provider Qualifications

License *(specify):*

Clinical Professional(s) License (e.g. Physical Therapist, Occupational Therapist, Rehabilitation Engineer, etc.)

Certificate *(specify):*

Specialized Certification in Home Modifications

Other Standard *(specify):*

Enroll as a Medicaid Environmental Accessibility Adaptation assessor, except for those providers who choose to sub-contract with an OHCDS that is an enrolled Medicaid provider.

Must sign OAAS Provider Attestation form.

Must comply with all LDH rules and regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Aging and Adult Services (OAAS)

Frequency of Verification:

Initial

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:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Up to two (2) nutritionally balanced meals per day may be delivered to the home of an eligible participant who is unable to leave his/her home without assistance, unable to prepare his/her own meals, and/or has no responsible caregiver in the home. Each meal shall provide a minimum of one-third of the current recommended dietary allowance (RDA) for the participant as adopted by the United States Department of Agriculture. The provision of home delivered meals does not provide a full nutritional regimen. The meal is delivered to the participant's home.

The purpose of home delivered meals is to assist in meeting the nutritional needs of an individual in support of the maintenance of self-sufficiency and enhancing the quality of life.

Participants with specific chronic conditions may receive Medically Tailored Meals (MTMs). Up to two (2) MTMs are available for up to twelve (12) weeks after discharging from the hospital and/or nursing facility. MTMs must be developed under the supervision of a Registered Dietitian Nutritionist (RD/RDN) or Licensed Dietitian Nutritionist (LDN) and comply with the Dietary Guidelines for Americans as published by the United States Department of Health and Human Services (HHS) and the United states Department of Agriculture (USDA), meet the current recommended dietary allowance (RDA)/dietary reference intakes (DRI) established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences and follow current standards for specific diseases or conditions.

Participants with specific chronic conditions receiving MTMs may also receive nutrition counseling from a Registered Dietitian (RD), Registered Dietitian Nutritionist (RDN) or a Licensed Dietitian Nutritionist (LDN) to support healthy food choices for their third meal and snacks. This service includes an evaluation that is specific to the participant’s medical diagnosis and a medically appropriate nutrition care plan that follows current standards for specific diseases or conditions.

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

MTMs are included as part of the State's approved HCBS Spending Plan authorized under Section 9817 of the ARPA through March 31, 2025 or until the State's authorized funding is exhausted.

Participants will either receive regular Home Delivered Meals or MTMs. For MTMs, participants are limited to receiving this service for up to twelve (12) weeks post hospitalization/discharge from the nursing facility. Nutritional counseling is limited to three (3) sessions per 12 weeks of MTM home delivery post discharge from a hospital or nursing facility.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Home Delivered Meals

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Home Delivered Meals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

In-state providers must meet LDH Public Health certification, permit and inspection requirements for retail food preparation, processing, packaging, storage and distribution or contract with an entity that meets said requirements.

Out-of-state providers must meet all USDA food preparation, processing, packaging, storage and out-of-state distribution requirements. Must meet home state of operations requirements for food preparation, processing, packaging, storage and distribution.

Other Standard *(specify):*

Must enroll as Home Delivered Meals provider, except for those providers who choose to sub-contract with an OHCDS that is an enrolled Medicaid provider.

Must comply with all LDH rules and regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Provider Enrollment, local public health, and/or USDA inspectors

Frequency of Verification:

Initially and periodically by local public health and/or USDA inspector

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:

Housing Stabilization Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Housing Stabilization Services enables waiver participants to, once housed, successfully maintain tenancy and residence in their own housing as set forth in the participant's approved plan of care (POC). Services must be provided in the home or a community setting. The service includes the following components:

1. Participate in plan of care renewal and updates as needed, to incorporate elements of the housing support plan. If additional supports or services are identified as needed outside the scope of Housing Stabilization Services, communicate those needs to the Support Coordinator.

2. Provide supports and interventions designed to maintain ongoing successful and stable tenancy and residence as per the individualized housing support plan.

3. Serve as point of contact for the landlord or property manager regarding any accommodations needed by the participant, any components of emergency procedures involving the landlord or property manager, and to assist with issues that may place the participants housing at risk.

4. Update the Housing Support Plan annually or as needed due to changes in the participant's situation or status.

This service is available to participants during a temporary stay in a nursing facility or hospital.

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

This service is only available upon referral from the support coordinator. This service is not duplicative of other waiver services
including Support Coordination. This service is only available to persons who are residing in a State of Louisiana Permanent Supportive Housing unit. No more than 72 units of Housing Stabilization Services can be used per year without written approval
from the Support Coordinator. No more than 168 units of Housing Transition or Crisis Intervention and Housing Stabilization
Services can be used per year without written approval from the support coordinator.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Permanent Supportive Housing Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Housing Stabilization Services

Provider Category:

Agency

Provider Type:

Permanent Supportive Housing Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Community Psychiatric and Support Teams

Other Standard *(specify):*

Permanent Supportive Housing (PSH) Agency under contract and enrolled with all contracted Medicaid managed care plans for the state of Louisiana, plus either:
1. meeting requirements for completion of training program as verified by the PSH director; or

2. have at least one year of completion of housing support team experience in the PSH program as verified by the PSH director.

Verification of Provider Qualifications

Entity Responsible for Verification:

OAAS

Frequency of Verification:

Initially 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:

Housing Transition or Crisis Intervention Services

HCBS Taxonomy:

Category 1: 17 Other Services

Sub-Category 1: 17030 housing consultation

Category 2: 17 Other Services

Sub-Category 2: 17990 other

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Housing Transition Crisis or Intervention Services enable participants who are transitioning into a PSH unit, including those transitioning from institutions, to secure their own housing. Assistance may also be provided at any time the participant's housing is placed at risk (e.g., eviction, loss of roommate or income). The service includes the following components:

1. Conduct a housing assessment identifying the participant's preferences related to housing (type, location, living alone or with someone else, accommodations needed, other important preferences) and needs for support to maintain housing (accessibility of housing; becoming familiar with neighborhood, resources, and neighbors; meeting terms of lease; eviction prevention; budgeting for housing/living expenses; obtaining/accessing sources of income necessary for rent; home management; and understanding and meeting obligations of tenancy as defined in lease terms).
2. Assist participant to view and secure housing as needed. This may include arranging or providing transportation. Assist participant to secure supporting documents/records, complete and submit housing applications, secure or seek waiver of deposits, and locate furnishings.
3. Develop an individualized housing support plan based upon the housing assessment that includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goals, and identifies where other provider(s) or services may be required to meet the goal.
4. Participate in the development of the plan of care, incorporating elements of the housing support plan.
5. Look for alternatives to housing if permanent supportive housing is unavailable to support completion of transition.
6. Communicate with the landlord or property manager regarding any accommodations needed by the participant, any components of emergency procedures involving the landlord or property manager, and to assist with issues that may place the participant's ability to access or remain in housing at risk.
7. If at any time the participant's housing is placed at risk (e.g., eviction, loss of roommate or income), Housing Transition or Crisis Intervention Services will provide supports to retain housing or locate and secure housing to continue community based supports including locating new housing, sources of income, etc.

This service is available to participants during transition from a nursing facility to the community and during a waiver participant's temporary stay in a nursing facility or hospital.

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

This service is only available upon referral from the support coordinator. This service is not duplicative of other waiver services
including Support Coordination. This service is only available to persons who are residing in a State of Louisiana Permanent Supportive Housing unit or who are linked for the State of Louisiana Permanent Supportive Housing selection process. No more than 96 units of Housing Transition or Crisis Intervention can be used per year without written approval from the Support
Coordinator. No more than 168 units of Housing Transition or Crisis Intervention and Housing Stabilization Services can be used per year without written approval from the support coordinator.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

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	Permanent Supportive Housing Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Housing Transition or Crisis Intervention Services

Provider Category:

Agency

Provider Type:

Permanent Supportive Housing Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Community Psychiatric and Support Teams

Other Standard *(specify):*

Permanent Supportive Housing (PSH) Agency under contract and enrolled with all contracted Medicaid managed care plans for the state of Louisiana, plus either:
1. meeting requirements for completion of training program as verified by the PSH director; or
2. have at least one year of completion of housing support team experience in the PSH program as verified by the PSH director.

Verification of Provider Qualifications

Entity Responsible for Verification:

OAAS

Frequency of Verification:

Initial and annual 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:

Monitored In-Home Caregiving

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Monitored In-Home Caregiving are services provided to a participant living in a private home with a principal caregiver. The goal of this service is to provide a community-based option that provides continuous care, supports, and professional oversight. This goal is achieved by promoting a cooperative relationship between a participant, a principal caregiver, the professional staff of a Monitored In-Home Caregiver agency provider, and the participant's support coordinator.

The principal caregiver is responsible for supporting the participant to maximize the highest level of independence possible by providing necessary care and supports that may include:

1. Supervision or assistance in performing activities of daily living.
2. Supervision or assistance in performing instrumental activities of daily living.
3. Protective supervision provided solely to assure the health and welfare of a participant.
4. Supervision or assistance with health related tasks (any health related procedures governed under the Nurse Practice Act) in accordance with applicable laws governing the delegation of medical tasks/medication administration.
5. Supervision or assistance while escorting / accompanying the individual outside of the home to perform tasks, including instrumental activities of daily living, health maintenance or other needs as identified in the plan of care, and to provide the same supervision or assistance as would be rendered in the home.
6. Extension of therapy services to maximize independence when the caregiver has been instructed in the performance of the activities by a licensed therapist or registered nurse.

Monitored In-Home Caregiving providers must be agency providers who employ professional nursing staff and other professionals to train and support caregivers to perform the direct care activities performed in the home. The agency provider must assess and approve the home in which services will be provided, and enter into contractual agreements with caregivers who the agency has approved and trained. The agency provider will pay a per diem stipend to caregivers.

The agency provider must capture daily notes electronically and use the information collected to monitor participant health and caregiver performance. The agency provider must make such notes available to support coordinators and the state, upon request.

LDH will reimburse for Monitored In-Home Caregiving based on a two tiered model which is designed to address the participant's acuity.

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

Participants electing Monitored In-Home Caregiving are not eligible to receive the following Community Choices Waiver services: Personal Assistance Services and Home Delivered Meals during the period of time the participant is receiving Monitored In-Home Caregiving.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

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	Monitored In-Home Caregiving

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Monitored In-Home Caregiving

Provider Category:

Agency

Provider Type:

Monitored In-Home Caregiving

Provider Qualifications

License *(specify):*

Must be licensed according to Louisiana Revised Statute (R.S. 40:2120.2).

Certificate *(specify):*

Other Standard *(specify):*

Must enroll as a Medicaid Monitored In-Home Caregiving provider.

Must comply with LDH rules and regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Standards Section

Frequency of Verification:

Initial and as deemed 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:

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:

Nursing

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Nursing services are services that are medically necessary and may only be provided efficiently and effectively by a nurse practitioner or registered nurse, or a licensed practical nurse working under the supervision of a registered nurse. These nursing services must be provided within the scope of the Louisiana Statutes governing the practice of nursing. Nursing services may include periodic assessment of the participant's medical condition when the condition requires a skilled nurse to identify and evaluate the need for medical intervention or to monitor and/or modify the medical treatment services provided by non-professional care providers. Services may also include regular, ongoing monitoring of a participant's fragile or complex medical condition as well as the monitoring of a participant with a history of noncompliance with medication or other medical treatment needs. Nursing may also be used to assess a participant's need for assistive devices or home modifications, training the participant and family members in the use of the purchased devices, and training of DSWs in tasks necessary to carry out the Plan of Care.

This service is available to participants during a temporary stay in a nursing facility or hospital.

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

Where applicable, participant must use Medicare, Medicaid State Plan services or other available payers first. The participant's preference for a certain staff or agencies is not grounds for declining another payer in order to access waiver services.

All services must be based on a verified need of the participant and the planning team. The service must have a direct or remedial benefit to the participant with specific goals and outcomes.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Must be licensed according to the Louisiana Revised Statutes (R.S. 40:2116.31).

Certificate *(specify):*

Other Standard *(specify):*

Must be enrolled as a Medicaid home health provider, except for those providers who choose to sub-contract with an OHCDS that is an enrolled Medicaid provider.

Must comply with all LDH rules and regulations.

Must sign OAAS Provider Attestation form.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Standards Section

Frequency of Verification:

Initial and as deemed 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:

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:

Personal Assistance Services (PAS)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Personal Assistance Services (PAS) provide assistance and/or supervision necessary for the participant with functional impairments to remain safely in the community.

PAS include the following services and supports based on the approved POC:
- Supervision or assistance in performing activities of daily living (ADLs);
- Supervision or assistance in performing instrumental activities of daily living (IADLs);
- Protective supervision provided solely to assure the health and welfare of a participant;
- Supervision or assistance with health related tasks (any health related procedures governed under the Nurse Practice Act) in accordance with applicable laws governing the delegation of medical tasks/medication administration);
- Supervision or assistance while escorting/accompanying the participant outside of the home to perform tasks including instrumental activities of daily living, health maintenance or other needs as identified in the plan of care and to provide the same supervision or assistance as would be rendered in the home; and
- Extension of therapy services as defined as follows: Licensed therapists may choose to instruct the attendants on the proper way to assist the participant in follow-up therapy sessions. This assistance and support provides reinforcement of instruction and aids in the rehabilitative process. In addition, a Registered Nurse may instruct an attendant to perform basic interventions with a participant that would increase and optimize functional abilities for maximum independence in performing activities of daily living such as range of motion exercises.

PAS is provided in the participant's home or in another location outside of the individual's home if the provision of these services allows the individual to participate in normal life activities pertaining to the ADLs and IADLs cited in the POC. IADLs can not be performed in the participant's home when the participant is absent from the home, unless it is approved by OAAS or it’s designee on a case-by-case basis. There shall be no duplication of services. PAS may not be provided while the participant is admitted to or attending a program which provides in-home assistance with ADLs or IADLs, or while attending or admitted to a program or setting where such assistance is provided.

PAS may be provided by one worker for up to three waiver participants who live together and who have a common direct service provider. Wavier participants may share PAS staff when agreed to by the participants and as long as the health and welfare of each participant can be reasonably assured. Shared PAS is to be reflected in the POC of each participant. Reimbursement rates shall be adjusted accordingly.

PAS may be provided through an a.m. and p.m. delivery option defined as follows:
*a minimum of 1 hour and a maximum of 2 hours of PAS provided to assist the participant at the beginning of his/her day, referred to as the a.m. portion of this PAS delivery method; and
*a minimum of 1 hours and a maximum of 2 hours to assist the participant at the end of his/her day referred to as the p.m. portion of this PAS delivery method; and
*a minimum 4 hours break between the a.m. and the p.m. portion of this PAS delivery method; and
*not to exceed a maximum of 4 hours of PAS being provided within a calendar day;
*a.m. and p.m. PAS cannot be shared and may not be provided on the same calendar day as other PAS delivery methods

It is permissible to receive only the a.m. or p.m. portion of PAS within a calendar day. However, "a.m." or "p.m." PAS may not be provided on the same calendar day as other PAS delivery methods.

PAS providers must be able to provide both regular and a.m./p.m. PAS and cannot refuse to accept a Community Choices Waiver participant solely due to the type of PAS delivery method that is listed on the POC.

The provision of PAS services outside of the participant's home does not include trips outside of the borders of the state without prior written approval of OAAS or its designee, through the POC or otherwise. Community Choices Waiver participants who receive PAS cannot receive Long Term-Personal Care Services. Home Health Agencies are limited to providing services within a 50 mile radius of its parent agency. It is permissible for the PAS allotment to be used flexibly in accordance with the participant's preferences and personal schedule and OAAS' documentation requirements.

Waiver participants who participate in self direction will also provide supervision of their PAS worker.

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

PAS cannot be received at the same time of day as Caregiver Temporary Support or ADHC services.

Participants are not permitted to receive PAS while living in a home or property owned, operated, or controlled by a provider of services who is not related to the participant.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

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	Personal Care Attendant
Agency	Home Health Agency
Individual	Direct Service Worker (DSW)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Assistance Services (PAS)

Provider Category:

Agency

Provider Type:

Personal Care Attendant

Provider Qualifications

License *(specify):*

Must be licensed according to the Louisiana Revised Statutes (R.S. 40: 2120.2).

Certificate *(specify):*

Other Standard *(specify):*

Must be enrolled as a Medicaid direct service provider, except for those providers who choose to sub-contract with an OHCDS that is an enrolled Medicaid provider.

Must comply with LDH rules and regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Standards Section

Frequency of Verification:

Initial and as deemed necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Assistance Services (PAS)

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Must be licensed according to the Louisiana Revised Statutes(R.S. 40:2116.31).

Certificate *(specify):*

Other Standard *(specify):*

Must be enrolled at a Medicaid Home Health provider, except for those providers who choose to sub-contract with an OHCDS that is an enrolled Medicaid provider.

Must comply with LDH rules and regulations.

Home Health Direct Service Worker (DSW)must be a qualified Home Health Aide as specified in the Louisianas Minimum licensing standards for Home Health Agencies.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Standards Section

Frequency of Verification:

Initial and as deemed necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Assistance Services (PAS)

Provider Category:

Individual

Provider Type:

Direct Service Worker (DSW)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must comply with LDH rules and regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Agent

Frequency of Verification:

Initial and on-going

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:

Skilled Maintenance Therapy

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11080 occupational therapy
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11090 physical therapy
Category 3:	**Sub-Category 3:**
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Choices Waiver participants may receive therapy services in the home or in a rehabilitative center. Unlike State

Plan in that under the State Plan therapy services, provision of therapy services under the Community Choices Waiver expands the provider base to Rehabilitative Centers and individually licensed therapists so that recipients may receive maintenance therapies either at home, work or at a rehabilitative center in order to increase access to therapy services.

Skilled Maintenance Therapy services include Physical Therapy, Occupational Therapy, and Speech and Language Therapy. Therapy services provided to participants under the Community Choices Waiver are not necessarily tied to an episode of illness or injury and instead focus primarily on the person's functional need for maintenance of, or reducing the decline in, the participant's ability to carry out activities of daily living. Skilled Maintenance Therapies may also be used to assess a participant's need for assistive devices or home modifications, training the participant and family members in the use of the purchased devices, performance of in-home fall prevention assessments, and participation on the POC planning team. Services may be provided in a variety of locations including the participant's home, place of employment, or a clinic as approved by the POC planning team.

Skilled Maintenance Therapy services specifically include:

Physical Therapy: Physical Therapy services promote the maintenance of or the reduction in the loss of gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities. Specific services may include: professional assessment(s), evaluation(s) and monitoring for therapeutic purposes; physical therapy treatments and interventions; training regarding PT activities, use of equipment and technologies ; designing, modifying or monitoring use of related environmental modifications; designing, modifying, and monitoring use of related activities supportive to the POC goals and objectives; or consulting or collaborating with other service providers or family members, as specified in the POC.

Occupational Therapy Services: Occupational Therapy Services promote the maintenance of or reduction in the loss of fine motor skills, coordination, sensory integration, and/or facilitate the use of adaptive equipment or other assistive technology. Specific services may include: teaching of daily living skills; development of perceptual motor skills and sensory integrative functioning; design, fabrication, or modification of assistive technology or adaptive devices; provision of assistive technology services; design, fabrication, or applying selected orthotic or prosthetic devices or selecting adaptive equipment; use of specifically designed crafts and exercises to enhance function; training regarding OT activities; and consulting or collaborating with other service providers or family members, as specified in the POC.

Speech Language Therapy: Speech Language Therapy services preserve abilities for independent function in communication; facilitate oral motor and swallowing function; facilitate use of assistive technology, and/or prevent progressive disabilities. Specific services may include: identification of communicative or oropharyngeal disorders; prevention of communicative or oropharyngeal disorders; development of eating or swallowing plans and monitoring their effectiveness; use of specifically designed equipment, tools, and exercises to enhance function; design, fabrication, or modification of assistive technology or adaptive devices; provision of assistive technology services; adaptation of the participants environment to meet his/her needs; training regarding SLT activities; and consulting or collaborating with other service providers or family members, as specified in the POC.

Skilled Maintenance Therapy evaluations/assessments are available to participants during a waiver participant's temporary stay in a nursing facility or hospital.

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

Where applicable, the participant must use Medicaid state plan, Medicare or other available payers first. The participant's preference for a certain therapist or agency is not grounds for declining another payer in order to access waiver services.

All services must be based on a verified need of the participant and the service must have a direct or remedial benefit to the participant with specific goals and outcomes.

The authorized service will be reviewed/monitored by the support coordinator to verify the continued need for the service and that the service meets the participant's needs in the most cost effective manner.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Maintenance Therapy

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Must be licensed according to the Louisiana Revised Statutes (R.S. 40:2116.31).

Certificate *(specify):*

Other Standard *(specify):*

Must enroll as a Medicaid Home Health Agency, except for those providers who choose to sub-contract with an OHCDS that is an enrolled Medicaid provider.

Must comply with all LDH rules and regulations.

Must sign OAAS Provider attestation form.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Standards Section

Frequency of Verification:

Initial and as deemed 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:

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:

Transition Intensive Support Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services that will assist participants who are currently residing in nursing facilities in gaining access to needed waiver and other State plan services, as well as needed medical, social, housing, educational and other services, regardless of the funding source for these services. Support coordinators shall initiate and oversee the process for assessment and reassessment, as well as be responsible for ongoing monitoring of the provision of services included in the participant's approved Plan of Care (POC). This service is paid up to 6 months (no more than 180 calendar days) prior to transitioning from the nursing facility when adequate pre-transition supports and activity are provided and documented.

The scope of Transition Intensive Support Coordination does not overlap with the scope of support coordination.

This service is available to participants during transition from a nursing facility to the community.

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

Support coordinators may assist individuals with their transitioning up to 6 months (no more than 180 calendar days)while the individual is still residing in the nursing facility.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Support Coordination Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Intensive Support Coordination

Provider Category:

Agency

Provider Type:

Support Coordination Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified as a case management (support coordination) agency by LDH/OAAS.

Other Standard *(specify):*

Must enroll as a Medicaid Support Coordination Agency (SCA) provider.

Must sign and comply with the OAAS SCA performance agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

OAAS

Frequency of Verification:

Initial and annual

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:

Transition Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Transition Services are time limited, non-recurring set-up expenses available for individuals who have been offered and approved for a Community Choices Waiver opportunity and are transitioning from a nursing facility to a living arrangement in a private residence where the individual is directly responsible for his/her own living expenses. Allowable expenses are those necessary to enable the individual to establish a basic household that does not constitute room and board, but includes: security deposits that are required to obtain a lease on an apartment or house; specific set up fees or deposits (e.g. telephone, electric, gas, water and other such necessary housing set up fees or deposits including outstanding balances that are essential to securing housing in the community); activities to assess need, arrange for and procure need resources (e.g. cost to obtain birth certificate, picture ID and housing application fees); essential furnishings to establish basic living arrangements; and health and welfare assurances (e.g. pest control/eradication, fire extinguisher, smoke detector and first aid supplies/kit). These services must be prior approved in the participant's plan of care. These services do not include monthly rental, mortgage expenses, food, recurring monthly utility charges and household appliances and/or items intended for purely recreational purposes. These services may not be used to pay for furnishing or set-up living arrangements that are owned or leased by a waiver provider. Support coordinators shall exhaust all other resources to obtain these items prior to utilizing the waiver.

This service is available to participants during transition from a nursing facility to the community.

The scope of Transition Services does not overlap with services covered through the Money Follows the Person (MFP) program, therefore duplicate billing will not occur.

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

$1,500 lifetime maximum per participant. When the participant requires services that exceed the lifetime maximum allowed, OAAS staff and/or the support coordinator shall identify and refer the participant and/or responsible representative to additional resources through the Aging and Disabled Resource Center (ADRC), Council on Aging, Governor's Office of Elderly Affairs (GOEA), informal supports, etc.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Support Coordination Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Service

Provider Category:

Agency

Provider Type:

Support Coordination Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified as a case management (support coordination) agency by LDH/OAAS.

Other Standard *(specify):*

Must enroll as a Medicaid Support Coordination Agency (SCA) provider.

Must sign and comply with the OAAS SCA Performance Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

OAAS

Frequency of Verification:

Initial and annual

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 section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

No services selected for remote delivery

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 Louisiana State Police (LSP), or the LSP designee, perform the actual criminal history/background checks and security check on individuals who provide waiver services.

A sample of employee criminal history/background checks are reviewed by Health Standards Section (HSS) during licensing reviews. HSS is the regulatory agency for LDH. HSS licenses Direct Service Providers (DSPs) and ADHC providers and ensures compliance with the applicable rules and regulations. OAAS reviews criminal history/background checks for the Support Coordination Agencies (SCAs) and ensures compliance with the applicable rules and regulations.

State law mandates that SCAs, DSPs and ADHC providers conduct criminal history/background checks and sex offender checks on all non-licensed personnel at the time an offer of employment is made. HSS surveyors will assess the provider’s compliance with the requirement at the time surveys are conducted. OAAS will assess the SCA's compliance with the requirement at the annual monitoring.

The LSP, or the LSP designee company that they recognize as competent, perform the actual criminal history/background checks on the individual.

OAAS also follows the policy in the LA Revised Statutes for the persons working with the elderly and adults who are disabled:
-LA R.S. 15:1501-1511 Abuse and Neglect of Adults; and
-LA R.S. 40:1203.2 -1203.3 Criminal History Checks on Non-Licensed Persons and Licensed Ambulance Personnel

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; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. 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):

LDH maintains the Louisiana (LA) State Adverse Actions List Search database. This database includes information concerning persons that have any documentation of any findings of abuse, neglect, extortion, exploitation and misappropriation of property and/or funds. If a person's name appears on this search and the offense is listed in R.S. 40:1203.3, they are prohibited from employment.

This database also contains the names of workers, including certified nursing assistants and nurse aides with current certifications that have substantiated findings of abuse, neglect, exploitation and misappropriation of property and/or funds. These findings would be placed after the individual has been formally notified by a certified letter that the allegation(s) have been brought against them and they have been afforded their right to an informal reconsideration and/or administrative appeal. In addition to the LA State Adverse Actions List Search, criminal history/background checks are done in accordance with LA R.S. 40:1203.1-5.

- The criminal background check is a statewide check.
- Additionally, a security check is required which is a search of the national sex offender registry.

The Office of Inspector General (OIG) maintains the OIG List of Excluded Individuals database that contains national exclusions for individuals and/or providers, including those excluded by LDH.

Both the LA State Adverse Actions Search List and the OIG List of Excluded Individuals databases are to be checked upon hire and monthly thereafter.

Providers are required to verify upon hire and every month thereafter, that none of their staffs' names appear in the databases. HSS surveyors will review a sample of employee files to assess the providers' compliance with the requirement at the time surveys are conducted.

Support Coordination Agencies (SCAs) are required to verify upon hire and every month thereafter, that none of their staffs' names appear in the databases. OAAS will review a sample of employee files to assess the SCAs' compliance with the requirement at the annual monitoring.

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

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 or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which

payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring 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.*

For Personal Assistance Services (PAS), legally responsible individuals, the participant's spouse, may be the worker.

Upon review of the interRAI home care assessment, legally responsible individuals may be the worker when extraordinary care is identified. Extraordinary care is defined as exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization. The state further defines extraordinary care as behavioral, dementia related or nursing care needs identified in the assessment and/or Plan of Care (POC), such as but not limited to the following:

- oxygen;
- tube feeding;
- suctioning;
- physical therapy/occupational therapy
- incontinence, urinary collection device or ostomy;
- stage 4 or non-codeable pressure ulcers;
- dialysis; and/or
- hospice.

The legally responsible individuals must meet the provider qualifications (specified in Appendix C-3) that the state has established for PAS.

This waiver has an annual budget amount; therefore, the state does not limit the amount of PAS hours a legally responsible individual may work.

The state or its designee ensures that the provision of services by a legally responsible individual is in the best interest of the participant and must be documented on the POC. To ensure that payments are accurate for the services rendered, OAAS monitors and oversees the requirements of the provider through the prior authorization process and the approved POC.

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 types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures 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.

For PAS, relatives and/or legal guardians are allowed to be the worker. For MIHC, relatives, including the spouse, and/or legal guardians are allowed to be the principal caregiver.

The relatives and/or legal guardians must meet the provider qualifications (specified in Appendix C-3) that the state has established for PAS and MIHC.

To ensure that payments are accurate for the services rendered, OAAS monitors and oversees the requirements of the provider through the prior authorization process and the approved 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:

For the following Community Choices Waiver providers, prospective providers must undergo a Facility Need Review process through LDH:
- Adult Day Health Care (ADHC)
- Personal Care Attendant (PCA)
- Monitored In-Home Care (MIHC)
- Respite

The above providers must:
1. Obtain Facility Need Review (FNR) approval from LDH.(No impact to current providers)
2. Complete all HSS licensing requirements as outlined in the initial licensure packet (The licensing site is https://ldh.la.gov/page/427).
3. Complete Medicaid enrollment through LDH's fiscal intermediary by completing the basic enrollment packet in addition to the specific provider type packet. These enrollment packets may be found at http://www.lamedicaid.com/provweb1/Provider_Enrollment/newenrollments.htm

Support Coordination Agencies must:

1. Obtain certification approval from OAAS. Certification approval includes an on-site visit from OAAS staff to confirm compliance with all requirements set forth in the certification standards.
2. Sign the OAAS SCA Performance Agreement.
3. Complete Medicaid enrollment through LDH's fiscal intermediary by completing the basic enrollment packet in addition to the OAAS Case Management(Support Coordination) provider type packet. These enrollment packets may be found at http://www.lamedicaid.com/provweb1/Provider_Enrollment/newenrollments.htm.

Following completion of the above steps, the provider is listed on the Provider Freedom of Choice form for the appropriate service areas for which they have completed the enrollment and certification processes.

LDH allows all other interested provider types to participate in an enrollment and/or licensing process through LDH. The main LDH website is https://ldh.la.gov/. If the interested provider is unable to access the websites, the provider enrollment information can be mailed or given over the phone. The provider enrollment site is http://www.lamedicaid.com/provweb1/Provider_Enrollment/ProviderEnrollmentIndex.htm. Providers sign a Provider Enrollment agreement (PE-50) with Medicaid. They are enrolled through a LDH fiscal intermediary. Where licensing is required, providers are licensed through the Medicaid Health Standards Section (HSS) to deliver specific types of services to a specific population. All prospective providers must go through a provider enrollment on-site visit. The provider is listed on the Provider Freedom of Choice form for the appropriate service areas for which they have completed the enrollment and/or licensure processes. HSS notifies the OAAS state office when an enrolled provider is removed from the active Medicaid provider file and Provider Freedom of Choice listing. Notification will include the reason and the date of the closure.

Fiscal Employer Agents:

Prior to enrolling in Medicaid, Fiscal Employer Agent providers must complete the following process:

1. Obtain readiness review approval from Medicaid.
2. Sign the Medicaid Performance Agreement
3. Once the above are reviewed and approved by Medicaid, complete Medicaid provider enrollment through LDH's fiscal intermediary at the following link:
https://www.lamedicaid.com/Provweb1/Provider_Enrollment/ProviderEnrollmentIndex.htm

Following completion of the above steps, the provider is listed on the Provider Freedom of Choice form for the appropriate service area.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

- ○ **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- ○ **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By*

checking the boxes below, the state assures:

☐ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**

☐ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**

☐ **The HCBS must be identified in the individual's person-centered service plan; and**

☐ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

*And specify:***(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

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

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by 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 the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
C.a.i.a.1. Number and percentage of new HCBS providers who meet HCBS licensing standards prior to furnishing waiver services. Numerator=Number of HCBS providers who meet HCBS licensing standards prior to furnishing waiver services; Denominator= Total number of initials HCBS providers.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
C.a.i.a.2. Number and percentage of HCBS providers that continually meet HCBS licensing standards. Numerator = Number of HCBS providers that continually meet HCBS licensing standards; Denominator = Total number of licensed HCBS providers surveyed.

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

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

		Combination of complaint surveys and licensures
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
C.a.i.b.1 Number and percentage of unlicensed providers who meet Medicaid enrollment requirements. Numerator = Number of unlicensed providers who meet Medicaid enrollment requirements; Denominator = Total number of unlicensed

provider applicants.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
C.a.i.b.2-Number and percentage of Self-Direction employees who cleared criminal background checks prior to waiver services. Numerator=Number of Self-Directions employees who cleared criminal background checks prior to waiver services; Denominater=Total number of hired self-direction employees reviewed in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Fiscal Agent Report Review

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

Fiscal agent		
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
C.a.i.c.1. The number and percentage of HCBS licensed providers meeting annual provider training requirements in accordance with state laws/policies. Numerator = Number of HCBS licensed providers meeting annual provider training requirements in accordance with state laws/policies; Denominator = Total number of licensed HCBS providers surveyed.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify: Health Standards Section	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Combination of complaint surveys and licensures
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

C.a.i.a.1.and C.a.i.a.2
When conducting licensing surveys, Health Standards Section will monitor a 10% sample of Direct Service Worker (DSW) personnel files to ensure background checks are completed in accordance with state laws/polices. • Further, LDH is required to maintain a DSW registry to include information concerning any documentation of any investigation for findings of abuse, neglect, extortion, exploitation and misappropriation of property, including a summary of findings after an action is final. The provider is required to check the DSW registry upon hire and every 6 months to determine if a prospective hire is registered. When conducting licensing surveys, Health Standards Section will monitor a 10% sample of Direct Service Worker (DSW) personnel files to ensure a DSW registry check is done upon hire and every 6 months.

- For every deficiency cited, the provider shall submit a plan of correction. If acceptable, a follow-up survey will be conducted. The follow-up survey will be conducted either by on-site visit or via written evidence submitted by the provider, depending on the deficiency citations. The plan of correction will require the provider to give a completion date (no more than 60 days) for each deficiency as well as the staff person responsible for monitoring and assuring continued compliance. Failure to achieve substantial compliance may result in a provisional license, non-renewal, license revocation and cancellation of the Medicaid provider agreement. Civil monetary penalties may be imposed for deficiencies resulting in abuse, neglect, actual harm or death or when there are repeat deficiencies within an 18 month period. Failure to pay civil monetary penalties will result in withholding money from vendor payment.
- If a provisional license is issued, an on-site follow-up survey will be conducted prior to the expiration of the provisional license. A provisional license may be issued for a maximum period of six months. If the on-site follow-up survey determines that the provider has not corrected the deficient practices, the department may choose to not offer license renewal or a license revocation process may be initiated.

C.a.i.c.1.
- When conducting licensing surveys, Health Standards Section will monitor a 10% sample of personnel files to ensure

required initial and annual training are completed in accordance with state regulations.

• For non-compliance, deficiencies shall be cited and the provider shall submit a plan of correction. If acceptable, a follow-up survey will be conducted. The follow-up survey will be conducted either by onsite visit or via written evidence submitted by the provider, depending on the deficiency citations. The plan of correction will require the provider to give a completion date (no more than 60 days) for each deficiency as well as the staff person responsible for monitoring and assuring continued compliance. Failure to achieve substantial compliance may result in a provisional license, non-renewal, license revocation and cancellation of the Medicaid provider agreement. Civil monetary penalties may be imposed for deficiencies resulting in abuse, neglect, actual harm or death or when there are repeat deficiencies within an 18 month period. Failure to pay civil monetary penalties will result in withholding money from vendor payment.

• If a provisional license is issued, an on-site follow-up survey will be conducted prior to the expiration of the provisional license. A provisional license may be issued for a maximum period of six months. If the on-site follow-up survey determines that the provider has not corrected the deficient practices, the department may choose to not offer license renewal or a license revocation process may be initiated.

FEAs will be expected to comply with all items in the performance agreement. The performance agreement will be used as the monitoring tool. FEAs will be given a corrective action plan and/or may be required to pay a penalty.
Medicaid will monitor all FEA providers annually.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

(a) The waiver services to which the limit applies - The limits apply to all waiver services except Transition Services.
(b) The basis of the limit - Each Community Choices Waiver applicant is assessed using a uniform assessment tool. The interRAI assessment tool is designed to verify that an individual meets a nursing facility Level of Care and to identify an individual's need for support.

The interRAI assessment tool generates a score that assigns the individual being assessed to a Resource Utilization Groups (RUG-III/HC).

There are seven primary RUG-III/HC categories, each of which has subcategories that take into account the assistance needed for various ADLs and IADLs. These are:

1. Special Rehabilitation: Persons grouped in the Special Rehabilitation categories have had at least 120 minutes of rehab therapy
(Physical, Occupational, or Speech) within the 7 days prior to their assessment.

2. Extensive Services: Persons grouped in the Extensive Services categories are those with medium to high level of ADL need along with one or more of the following services:
- Tracheostomy
- Ventilator/Respirator
- Suctioning

3. Special Care: Persons grouped in the Special Care categories are those with medium to high level of ADL need along with one or more of the following conditions or require one or more of the following treatments:
- Stage 3 or 4 pressure ulcers
- Tube feeding
- Diagnosis of multiple sclerosis
- Quadriplegia
- Treatment of burns
- Radiation treatment
- IV Medications or
- Fever and one or more of:
  - o dehydration
  - o diagnosis of pneumonia
  - o vomiting
  - o unintended weight loss

4. Clinically Complex: Persons grouped in the Clinically Complex categories are those with specific clinical diagnoses or require the specified treatments:
- Dehydration
- Any stasis ulcer (a breakdown of the skin caused by fluid build-up in the skin from poor circulation)
- End-stage/terminal illness
- Chemotherapy
- Blood transfusion
- Skin problem
- Diagnosis of cerebral palsy
- Diagnosis of urinary tract infection (in the last 30 days)
- Diagnosis of hemiplegia (total or partial inability to move experienced on one side of the body caused by brain disease or injury)
- Dialysis treatment
- Diagnosis of pneumonia
- One or more of the eight (8)criteria in Special Care (with low ADL need) or
- One or more of the three (3)criteria in Extensive Services (with low ADL need)

5. Impaired Cognition: Persons grouped in the Impaired Cognition categories are those with low to medium ADL need along with impairment in cognitive ability. For example, this grouping will include persons with short-term memory loss, trouble in decision-making, difficulty in making themselves understood by others, and

in eating performance.

6. Behavior Problems: Persons grouped in the Behavior Problems categories are those with low to medium ADL need along with behavior problems. This category includes those individuals that may have socially inappropriate behavior, are physically or verbally abusive, have hallucinations or exhibit wandering behavior.

7. Reduced Physical Function: Persons grouped in the Reduced Physical Function category are those that did not fall into one of the previous categories.

Based on the RUG III/HC score, the applicant is assigned to a level of support category (as described above) and receives an annual budget for use in working with a Support Coordinator (SC) to design a Plan of Care (POC). The applicant and the SC have flexibility to construct a POC that best serves the applicant's health and welfare needs. All services approved pursuant to the POC must be medically necessary and provided in a cost-effective manner.

The case mix index for each RUG-III/HC level is based on historical utilization for the Community Choices Waiver. The case mix index is a relative measure that describes the relationship of each level to the overall mean. To ensure cost-effectiveness, the overall mean must be less than or equal to the average institutional cost.

(c) How the limit will be adjusted over the course of the waiver period - Utilization data is reviewed at least annually and the case mix index may be adjusted based on this review.

(d) Provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state - Assigned levels of support categories are based upon needs identified through the assessment process consistent with the requirement to maintain cost neutrality. The SC or RO can initiate a review of the assigned level of support category if there are concerns about the health and welfare of the participant. Based on that review, exceptions may be made to the specific RUG group limits and persons may be assigned a higher budget limit if it is necessary to prevent institutionalization. The participant may also appeal if they feel their needs are greater and may need to be placed in a higher level of support category. In addition, when the participant's needs exceeds those provided for via the assigned level of support category, the SC identifies and refers the participant and/or responsible representative to other waiver programs and/or additional resources through the Aging and Disabled Resource Center(ADRC), Council on Aging, Governor's Office of Elderly Affairs (GOEA), natural supports, etc.

(e) The safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs - In the event the applicant disagrees with his or her assigned level of support category and annual budget, the applicant, his/her responsible
representative, or an agency acting on behalf of the individual may file a request for an appeal for a fair hearing. The applicant may obtain additional services on a showing that an error was made in the assignment to the level of support category and/or needs additional services to avoid entering a nursing facility.

(f) How participants are notified of the amount of the limit - The "OAAS Rights and Responsibilities for Applicants/Participants of Home and Community-Based Waiver Services", which is given to participants, contains information regarding the Community Choices Waiver assessment based resource allocation method. Upon completion of the assessment and Plan of Care (POC), participants are advised by their SC of their budget limit based on their RUG-III/HC score. Participants may also request information on the Community Choices Waiver resource allocation method and budget limits through their OAAS ROs and/or SCs.

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

- ☐ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**
- ☐ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. *(see Appendix D-1-d-ii)***
- ☐ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**
- ☐ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**
- ☐ **Facilitates individual choice regarding services and supports, and who provides them.**
- ☐ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings*.)

- ○ **No, the waiver does not include provider-owned or controlled settings.**
- ○ **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):
  - ☐ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**
  - ☐ **Each individual has privacy in their sleeping or living unit:**

- ☐ **Units have entrance doors lockable by the individual.**
- ☐ **Only appropriate staff have keys to unit entrance doors.**
- ☐ **Individuals sharing units have a choice of roommates in that setting.**
- ☐ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**

☐ **Individuals have the freedom and support to control their own schedules and activities.**

☐ **Individuals have access to food at any time.**

☐ **Individuals are able to have visitors of their choosing at any time.**

☐ **The setting is physically accessible to the individual.**

☐ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

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. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(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:

- Bachelor's or Master's degree in social work from a program accredited by the Council on Social Work Education; or

- Bachelor's or Master's degree in nursing (RN) currently licensed in Louisiana (one year of paid experience will substitute for the degree);
or

- Bachelor's or Master's degree in a human service related field which includes: psychology, education, counseling, social services,
sociology, philosophy, family and participant sciences, criminal justice, rehab services, substance abuse, gerontology, and vocational
rehabilitation; or

- Bachelor's degree in liberal arts or general studies with a concentration of at least 16 hours in one of the fields listed above in the
human service related field; or

- Bachelor's or Master's degree in a field other than listed above, if approved by OAAS.

Additionally, case managers/support coordinators must meet all qualifications as specified in Appendix C-1/C-3.

☐ **Social Worker**

Specify qualifications:

☒ **Other**

Specify the individuals and their qualifications:

OAAS ROs may assist SCAs with completing person centered POCs upon SCA request or as deemed necessary by OAAS. RO staff completing all person centered POCs meet all qualifications listed above. In addition, any POCs are subject to review according to the State's existing annual SCA monitoring procedures.

Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *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.** ***Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the

potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

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.

Prior to the initial visit by the Support Coordinator (SC), the participant is sent a fact sheet describing the services available under the Community Choices Waiver. During the initial visit, the SC completes intake and assessment functions and may also conduct Plan of Care development. The SC explains to those present the range of services and supports available in the CC Waiver. Questions are answered as simply and clearly as possible to afford the individual every opportunity to gain a full understanding of program requirements and services. The SC may schedule follow-up POC development and/or review meetings with the participant and members of their support network. The planning team may include anyone requested by the participant; but, at a minimum, will include the individual, their representative (if applicable) and the SC. The team may also include members of the individual's family or informal support system, or professional personnel chosen by the individual. A direct service worker (DSW) or provider representative may participate, if that is requested by the individual. Professional service providers may also be included in the care planning process based on the assessment results, when warranted. SCs are trained by the Office of Aging and Adult Services (OAAS) to use person-centered planning methods and tools during initial visits in order to identify those individuals who should participate in planning meetings.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

A. The Support Coordinator (SC) is responsible for assuring that the initial Plan of Care (POC) is completed timely, reviewed annually, and updated as needed. The SC must conduct a POC meeting with the participant and/or legal or responsible representative and members of his/her social and professional supports network or circles of informal supports. Other professionals providing services under the waiver may be included in the care planning process based on the assessment results, when warranted. The waiver participant may choose his/her responsible representative and other of his/her choosing to assist in developing the POC. A meeting, face-to-face or virtually, scheduled at a time and location that is convenient for the participant. The SC also works with the participant and/or responsible or legal representative and members of his/her social supports network or circles of informal supports to convene subsequent POC update meetings.

The State is requiring the following visits to be face-to-face: assessment visit and at least 1 quarterly visit. There is not a predetermined percentage of time that virtual visits will occur since the individual/participant must agree that they would like a virtual visit in lieu of a face-to-face meeting.

SCAs will receive written instructions on the delivery of virtual services based on the HIPAA compliance officer's instructions.
When using virtual delivery, SCAs will follow these guidelines:
• Confidentiality still applies for services delivered through virtual delivery. The session must not be recorded without consent from the participant and/or responsible representative (as applicable).
• Verify participant's identity, if needed.
• The participant must be informed of all persons who are present and the role of each person.
• Participants may refuse this virtual option.
• It is important for the SC and the participant to be in a quiet, private space that is free of distractions during the session.

When SCs are contacting participants via virtual contacts, the SCs must respect the participant's privacy as it relates to toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. SCs will ensure that participants understand the guidelines for participation in the virtual contacts. Written instructions will be provided to each participant.

SC virtual contacts will facilitate community integration by continuing to provide referrals, resources and services in their Plan of Care (POC). Through SC virtual contacts, participants can continue to interact with their family, friends and community connections when in-person services are not occurring.

If the participant requires hands on assistance/physical assistance to participate in a SC virtual contact and they do not have informal support to provide that assistance, the SC contact must be conducted face-to-face.

The SC will instruct the participant to understand how to utilize the technology required to participate in this SC virtual contact, including how to utilize the specific format, signing in and out. The SC will provide written instructions.

The SC will assess the participant during the SC virtual contact on their health and safety. If they feel like the participant's health and safety is in jeopardy, the SC will follow emergency protocols and/or follow up with face-to-face contact.

All forms completed through the evaluation and service plan process can be completed with an electronic signature or wet signature from the participant, responsible representative, legal representative, support coordinator and/or providers.

POC Time Frames:

Initial POCs:

- An SCA staff member must contact the participant and/or responsible representative within three (3) business days of receiving the Support Coordination Choice/Release of Information form (linkage) to schedule a face-to-face assessment.

- The SC must conduct a face-to-face intake assessment meeting within ten (10) business days of receiving the Support Coordination Choice/Release of Information form (linkage) to offer Freedom of Choice of provider(s)and explain all available services in the waiver.

- The SC supervisor must review/approve the participant's POC packet within thirty-five (35) calendar days (45 calendar days if the participant is currently in a nursing facility) of receiving the Support Coordination Choice/Release of Information form (linkage).

- Once Medicaid eligibility is approved and the POC packet is approved, the SC must send (via mail, fax, or email) the POC packet to the participant and/or responsible representative and the provider(s) on the same day as the final approval. In addition, the SC will contact the participant and/or responsible representative and the provider(s) on the same day as the final approval to notify him/her of the approval.

- The provider(s) has ten (10) calendar days from date of approval notification to initiate services.

- The SC must contact the participant within ten (10) calendar days from the date of provider service initiation to assure the appropriateness and adequacy of the service delivery.

B. The interRAI assessment tool is the comprehensive assessment used to gather information needed to develop the POC. In addition to the interRAI assessment tool, support coordinators may work with the individual to review and/or obtain other relevant health or psychosocial assessments performed by other service and healthcare providers, for instance hospice or home health agencies. SCs are also trained by OAAS in the use of person-centered assessment techniques in order to assure that the participant's preferences, goals and risks are addressed in the POC. This will result in a comprehensive POC that addresses all of the participant's needs.

C. Prior to the initial meeting with the SC, the individual is sent a fact sheet describing services under the Community Choices Waiver. At initial contact upon linkage to the Community Choices Waiver, the SC discusses the availability of all services in the waiver and reviews the freedom of choice form. The freedom of choice forms lists names of local providers enrolled in Medicaid and/or participating in the waiver, and this listing is also available on the OAAS website at: https://www.lamedicaid.com/apps/provider_demographics/provider_map.aspx. The SC uses this process and the FOC list to assist the individual with choosing services and providers.

D. The POC must be outcome-oriented, individualized and time limited (e.g., annual goals and related mile stones). Essential elements of the planning process include:

- Tailoring the POC to the participant's needs based on the on-going use of participant-focused assessment utilizing the interRAI assessment tool.

- Developing mutually agreed upon strategies to achieve or maintain inclusion of participant's desired outcomes, which rely on informal supports, natural community supports and appropriate formal paid services.

- Assisting the participant to make informed choices about all aspects of supports and services needed to achieve his/her desired outcomes which involves assisting him/her to identify specific, realistic needs, and choices.

- Incorporation of steps which empower the participant to develop/enhance independence, growth, self-advocacy, and self-management.

- Language shall be understandable to all parties involved.

E. Coordination of Services

During the assessment and care-planning process, the SC identifies services that are already being received by the participant and documents these on the POC. Depending on the nature of those services, the support coordinator may request and review formal assessments and other documents developed by other providers, and any documents that are relevant to the participant's needs, interests, strengths, preferences and desired outcomes. With the participant's input waiver and/or non waiver services are planned for and scheduled with existing services in mind and with care to avoid unnecessary or inappropriate duplication of services.

The SC informs the participant and/or his/her responsible representative of all available home and community-based services, as well as other community services outside of Medicaid.

The SC assists the participant to obtain the services identified in the approved POC assuring that they meet the participant's individual needs while assisting to initiate, develop and maintain an informal support network.

Any identified needs are addressed by the SC on the POC and referrals are made to appropriate providers for those needs that are beyond the scope of the Community Choices Waiver services.

The SC obtains the participant's authorization to secure appropriate services as detailed in the POC.

F. The SC is responsible for confirming that services have begun and for monitoring implementation. The SC monitors implementation through monthly phone calls to participants and/or to their legal/responsible representative, through quarterly face-to-face or virtual visits, as well as through the Electronic Visit Verification (EVV) system. SC will meet with Community Choices Waiver participants and/or legal/responsible representatives at least quarterly to verify/review documentation of service delivery and/or discuss the same with the participant. Twelve month re-assessments and POC meetings may account for a quarterly or monthly contact. The documents reviewed to verify service delivery include provider logs, which must be maintained in the home and EVV reports. Participant and representatives are also asked whether services are delivered according to the participants preferred schedule.

Monitoring of ongoing services includes a review of service delivery documentation for the previous calendar quarter including EVV and post-authorization data. The SC performs the following:

-Discuss the last quarter of service delivery with the participant or responsible representative;

-Determine whether all ongoing services in the POC were delivered in the amount, frequency, and duration specified in the service plan;

-If an ongoing service is not delivered according to the POC for the quarter, the SC shall assess the reason, remediate when applicable and document utilizing the Service Monitoring Codes on the Support Coordination Delivery (SCD) form.

Monitoring whether all types of services were delivered is completed during the final quarter of the POC year or month of discharge, when applicable. The SC performs the following:

-Determine whether all types of services in the POC were delivered within the plan year and enter the appropriate code for each applicable service;

-For any service types specified in the POC which were not delivered during the POC year, check the applicable reason code and enter supporting details in the narrative section;

-If an undelivered service is due to any reason requiring remediation, code as such and perform and document the required remediation activities.

G. How and when the plan is updated, including when the participant's needs change:

POC Changes:

- The POC is updated at least annually. In addition, the SCs continuously assess the need to update the POC due to any significant changes in the participant's circumstances or condition.

There are two (2) types of POC Revisions: Routine and Emergency

Routine POC Revisions:

Routine POC Revisions are due within five (5) calendar days from the date of the reported change.

NOTE: Unless a re-assessment was conducted and indicates a change in the participant's condition, then the Routine POC Revision is due fourteen (14) calendar days after the completion date of the re-assessment.

Emergency POC Revisions:

Emergency POC Revisions are due within twenty-four (24) hours from the date of the reported change.

The SCs assess participants and identify factors that put them at risk or may affect their health, and/or welfare throughout their POC year. This ongoing monitoring assesses the effectiveness of the support strategies and identifies changes of the participant's needs or other health and welfare concerns. The frequency and intensity of the monitoring must be adjusted to meet the needs of the participant and corresponds to the level of identified risk. However, the participant, legal and/or responsible representative, provider, or medical practitioner, with a signed consent agreement for communication, can request a POC review at any time when concerns about health and welfare arise. The SC and the provider(s) are responsible for informing the participant to contact the support coordinator to report any significant changes in his/her status. A significant change in status may require a re-assessment. A "significant change in status" is an improvement or decline in the participant's condition that is NOT temporary in nature, i.e. cannot be expected to resolve itself in a short period of time (e.g.,2 weeks).

NOTE: Participants may contact their SC at any time and may request a POC review. SCs must respond to participant requests for assistance.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☐ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☐ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☐ **A specific and individualized assessed need for the modification.**
- ☐ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☐ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☐ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☐ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☐ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☐ **Informed consent of the individual.**
- ☐ **An assurance that interventions and supports will cause no harm to the individual.**

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.

Support Coordinators (SCs) and providers assess participants and identify factors that put waiver participants at risk and affect, or may affect, their health and/or welfare through the initial medical certification and the annual plan of care (POC) process using the inter RAI assessment tool, as well as participant, family and provider input. Ongoing monitoring assesses the effectiveness of the support strategies and identifies changes in the participant's needs and/or other health and welfare concerns. The frequency and intensity of the monitoring must be adjusted to meet the needs of the participant and correspond to the level of identified risk.

The interRAI assessment tool includes specific Client Assessment Protocols (CAPs) that are "triggered" and identified for detailed planning based on the comprehensive assessment. Many of these CAPs address risks common among elders and adults with physical disabilities (e.g., falls, depression, dehydration, abuse, environmental hazards, etc.) SCs are required to address every triggered CAP.

SCs are also required to develop an emergency plan and monitor that it is current and viable. Direct care providers must provide a back-up staffing plan for every individual served to be used for back up if a direct service worker is not available as scheduled. SCs are required to monitor whether the individualized Back-up Staffing Plan is current and viable.

To ensure participants and providers have continuous access to support coordination, OAAS requires that the SCAs maintain a 24/7 emergency telephone contact number to assist with any emergencies occurring outside of normal business hours.

For self-direction, the participant's SC assists the participant in developing a functional back-up plan, which may include the use of direct care providers or other viable support systems, to ensure the participant's continuity of services.

An Individual Responsibility Agreement (IRA) is used when a participant expresses a desire to take responsibility for certain risks or to leave certain areas of concern unaddressed. Use of an IRA is an acknowledgment of the dignity of risk assumed by an individual. An IRA provides documentation, by participant signature that the participant freely chooses to assume the responsibility for an identified risk or area of concern and understands the consequences if the risk or concern goes unaddressed. The SC develops POCs for participants initially, annually, and whenever a significant change in status occurs. A "significant change in status" is an improvement or decline in the participant's condition that is NOT temporary in nature, i.e. cannot be expected to resolve itself in a short period of time (e.g.,2 weeks).

During the care planning process, all identified risks and areas of concern must be planned for and defined outcomes must be identified in the POC. The POC must document how each identified risk and area of concern is addressed and by whom, including all areas addressed by formal and informal supports. Any unaddressed risk should be closely scrutinized and deliberated by the care planning team. It is strongly recommended that the SCA consult with their RN consultant for a thorough review. After consulting with the participant, if an unaddressed risk poses a serious threat to the participant’s health and welfare and: (1) The resources cannot be found to meet the risk and (2) The participant expresses the preference to take responsibility for, or leave unaddressed, an identified risk, the use of an IRA should be considered.

In instances described above, the SC attempts to mitigate the risk utilizing available non-waiver community resources. If this cannot be accomplished, the SC will collaborate with OAAS to determine if an IRA is necessary to ensure health and safety. If the participant is a Nursing Facility (NF) transition case, the appropriate OAAS My Choice or OAAS My Place Transition Coordinator (TC) will take the lead in determining the need for the IRA and if necessary, developing and completing the IRA. IF the participant is a community waiver case, without TC involvement, the OAAS RO will take the lead in determining the need for the IRA and if necessary, developing and completing the IRA.

When the participant takes responsibility for a risk or concern, he/she must demonstrate how he/she will address the identified risk or concern. When the participant chooses to leave a risk unaddressed, he/she must express understanding of the consequences of leaving the risk unaddressed. The participant must have a clear understanding of the tasks, functions and supports that the service provider will not perform.

A responsible representative is not allowed to authorize an IRA but may participate in the negotiation process at the discretion of the participant. Only the participant and/or the legally authorized representative are allowed to authorize and sign an IRA. The participant must have the cognitive capacity to make informed decisions and understand what he is signing; OR when participants have a legally

authorized representative (i.e., legal guardian, medical power of attorney) this legally authorized representative must participate in negotiating the IRA and must be the one to sign if the participant does not have the cognitive ability to sign.

The IRA identifies all team members participating in the IRA: the participant, responsible or legal representative (if applicable), the SC, SCA RN Consultant, service provider(s) and OAAS representative(s) and includes signatures of the participating team members. The IRA identifies the risk or concern for which the participant agrees to take responsibility. The IRA includes details provided by the participant regarding specific plans to address the risk or concern. The IRA includes a statement describing potential consequences for the participant and notes that these consequences were explained to the participant.

If a Support Coordination Agency (SCA) fails to comply and/or is unable to comply with their requirements as a certified SCA, OAAS may perform the mandatory duties of the SCA to ensure the continuity of the participants' services and the participants' health and welfare.

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.

When the individual is offered the Community Choices Waiver, he/she may accept or deny the offer. If the individual accepts the offer, he/she chooses a Support Coordination Agency (SCA) through the Freedom of Choice (FOC) process. The data contractor is responsible for facilitating this process.

At initial contact with the participant, the Support Coordinator (SC) discusses the availability of all services in the waiver and shares the provider FOC forms. The FOC form is a list of names of all local Medicaid enrolled providers in the service area. This list is available on the OAAS website at:
https://www.lamedicaid.com/apps/provider_demographics/provider_map.aspx

The SC encourages the participant and his/her responsible representative to contact and interview providers that he/she is interested in, in order to make an informed choice.

The SC is responsible for advising the participant that changes in providers can be requested at any time, but only by the participant and/or responsible/legal representative. SCs must at each annual POC meeting remind participants that they may change providers. Any request for a change requires a completion of a provider FOC form. The SC is responsible for supplying the participant with a current listing of providers.

Alternative methods of communication are used as the situation arises. There are two (2) main ways to provide language services: oral and written language services (interpretation and translation, respectively) and have substantial flexibility in determining the appropriate mix and medium. Where needed, Braille type mediums and interpretive services can be provided.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Through an Interagency Agreement (IA) with the Operating Agency (OAAS), the Medicaid agency (BHSF) has delegated approval of POCs to OAAS. This is done to assure that OAAS is complying with all HCBS regulations related to service planning, is following the Community Choices Waiver Application requirements and is identifying areas of deficiency on the plans of care, and implementing appropriate corrective actions.

BHSF receives reports specific to the Community Choices Waiver which facilitate BHSF's oversight of the service plan approval processes. MPSW reviews current performance reports, determines need for new activities concerning quality and oversight in waiver programs and ensures adequate remediation enforcement.

The following operations reports are generated quarterly from the data contractor database and made directly to BHSF and OAAS:
- Program enrollment;
- LOC redeterminations;
- Service plan timeliness; and
- Service utilization.

During the POC development process, SCs are responsible for ensuring that all of the participant's health and welfare needs are addressed in the POC. If a SC is unable to fully address the participant's health and welfare needs in the POC, a referral is submitted to the OAAS RO/OAAS Service Review Panel (SRP). The OAAS RO and SRP reviews and makes the final determination as to whether the participant's health and welfare needs can be met in the CC Waiver. OAAS monitors participant's health and welfare through the annual support coordination monitoring process (See performance measure D.a.i.a.1 and D.a.i.a.2). OAAS submits this performance measure and remediation information, along with SRP health and welfare referral outcomes annually to BHSF.

Mortality Reports are generated by OAAS from the Medicaid Eligibility database, critical incident reporting database and public health vital records database annually and are submitted to BHSF.

Critical Incident Trend Reports are generated by OAAS quarterly from the critical incident reporting database and are submitted to BHSF (See Appendix G: Quality Improvement).

The SCA Monitoring Report is generated by OAAS from the SCA Monitoring database annually and submitted to BHSF (See Appendix D: Quality Improvement).

These reports are reviewed and acted upon by the Medicaid HCBS Oversight Committee which meets at least quarterly and is composed of representatives from the LDH Program Offices and BHSF.

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, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

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

Specify the other schedule:

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

applies):

☐ **Medicaid agency**

☒ **Operating agency**

☒ **Case manager**

☒ **Other**

Specify:

Community Choices (CC) Waiver providers

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, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Support Coordinator (SC) is responsible for monitoring the implementation of the POC and the participant's health and welfare.

The SC must contact the participant within ten (10) calendar days from the date of provider service initiation to assure the appropriateness and adequacy of the service delivery.

The SC monitors the approved services at least quarterly. This ongoing monitoring assesses the effectiveness of the support strategies and identifies changes in the participant's needs or other health and welfare concerns. The frequency and intensity of monitoring must be adjusted to meet the needs of the participant.

The SC may make unannounced visits to verify that the participant is receiving the services based on the schedule of the approved POC. The SC must conduct a monthly telephone call to the participant to ensure that services are being provided in accordance with the approved POC.

The SC conducts at least one quarterly face-to-face visit with the participant in his/her home. The other quarterly visits may be conducted virtually or face-to-face. At these quarterly visits, the SC evaluates the effectiveness of the support strategies and will make appropriate POC revisions as needed. Additionally, the SC meets with members of the planning team on an as needed basis to identify and address issues that affect the participant's health and welfare. The SC submits POC revisions to the LDH/OAAS RO.

During the monthly and/or quarterly contacts, the SC will assess the following:

- Participant’s services were furnished in accordance with the service plan;
- Participant’s access to waiver services identified in the service plan;
- Services meet the participant’s needs;
- Effectiveness of the participant’s back-up plans;
- Participant’s health and welfare; and
- Participant’s access to non-waiver services in their service plan, including health services

SCs are responsible for prompt follow-up and remediation of problems identified during participant contacts. Follow-up and remediation activities are documented in the Support Coordination Documentation (SCD). This documentation is part of the information reviewed by OAAS during annual representative sample record review as described in the Quality Improvement section of this appendix.

In instances when a SCA is unable to remediate problems with service plan implementation or health and welfare, they contact the OAAS RO staff who offer technical assistance until a problem has been resolved. When issues cannot be resolved at the RO level, the RO submits a referral to the Service Review Panel (SRP) with possible recommendations. SRP maintains records of decisions related to Plan of Care (POC) implementation and this data is shared with both the OAAS Quality Review Team and OAAS Executive Management when problems are identified which require systemic improvement.

Upon first becoming aware of alleged abuse, neglect, exploitation, or extortion OAAS RO, SCAs, and direct service providers (DSPs) report directly and immediately to Protective Services, who is responsible for investigating these incidents (as described in Appendix G-1). Additionally, SCs and DSPs are required to report, address, and track critical incidents (as described in G-1.b.). Final resolution of all critical incidents is through the OAAS regional waiver office RO staff in collaboration with the SCAs. The RO or its designee makes a final determination of when all necessary follow-up for health and welfare is complete.

The SC is the entity responsible for monitoring the implementation of the service plan and participant's health and welfare. The OAAS Quality Review Team will review quality data and information on a quarterly basis as part of operational reviews and will make recommendations for systemic improvement to the OAAS Executive Management Team. The OAAS Executive Management Team will consider all recommendations by the OAAS Quality Review Team and will authorize actions on quality initiatives to address problems identified. This process is described in greater detail in Appendix H-1.a.i. The SC monitors the implementation of the service plan and participant's health and welfare through monthly phone calls and quarterly contacts. The monitoring information is recorded utilizing the SCD protocol and the critical incident management system. If problems are identified, the SC reports it/them to his/her supervisor for

assistance with resolution. If the problem cannot be resolved within the SCA, then the OAAS RO staff is contacted for assistance. Appendix G-1.d describes the collaboration between SCs and OAAS RO staff in critical incident resolution. The process for changing providers is described in Appendix D-1-f.

The SCD requirements include three (3) major areas:

1. Contact and Service Monitoring Information (includes types of contact and service activities and remediation codes);
2. Participant Questions (includes risk assessment questions); and
3. Support Coordination Actions (includes actions taken to address any noted areas of concerns in the risk assessment).

These requirements:

1. Provide a guide for asking all of the required, key questions for monthly and quarterly contacts;
2. Provide a structured format to gain comprehensive information and effectively coordinate care and services;
3. Provide a format for the collection of information which covers many review elements of the OAAS quality assurance monitoring; and
4. Prompt SCs to ask appropriate questions and use critical thinking to ensure continual monitoring and POC Revisions to reflect the participant's current status.

The SCD includes risk assessment questions which prompt the SCs to reassess and update the POC, the emergency plan, and the backup staffing plan (if applicable).

If a Support Coordination Agency (SCA) fails to comply and/or is unable to comply with their requirements as a certified SCA, OAAS may perform the mandatory duties of the SCA to ensure the continuity of the participants' services and the participants' health and welfare.

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

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

○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual**

that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
D.a.i.a.4 Number and percent of participants with emergency plans which have been agreed to by the responsible parties. Numerator = Number of participants with emergency plans which contained an agreement signature by the responsible parties;Denominator = Total number of participants reviewed

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% + or -5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.a.i.a.2 Number and percent of participants whose service plans had strategies that addressed their health and safety risks as indicated in the assessment(s). Numerator = Number of participants whose service plans had strategies that addressed their health and safety risks as indicated in the assessment(s); Denominator = Total number of participants reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
D.a.i.a.1 Number and percent of participants who had service plans that addressed their needs (including health care needs) as indicated in the assessment(s). Numerator = Number of participants who had service plans that addressed their needs (including health care needs) as indicated in the assessment(s); Denominator = Total number of participants reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
D.a.i.a.3 Number and percent of participants whose service plans addressed their personal goals as indicated in the assessment(s). Numerator = Number of participants whose service plans address their personal goals as indicated in the assessment(s); Denominator = Total number of participants reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
D.a.i.a.5 Number and percent of participants with staffing back-up plans which have been agreed to by the responsible parties. Numerator = Number of participants with staffing back-up plans which contained an agreement signature by the responsible parties; Denominator = Total number of participants reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

Performance Measures

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

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

c. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope,***

amount, duration, and frequency specified in the service plan.

Performance Measures

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

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

Performance Measure:
D.a.i.c.2 Number and percent of waiver participants whose service plans were reviewed and revised as needed to address changing needs. Numerator = Number of waiver participants whose service plans were reviewed and revised as needed to address changing needs; Denominator = Total number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
D.a.i.c.1 Number and percent of participants whose service plans were updated as warranted, on or before waiver participants annual review date. Numerator = Number of participants whose service plans were updated as warranted, on or before waiver participants annual review date; Denominator = Total number of participants reviewed.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
D.a.i.d.2 Number and percent of participants who received services in the scope, amount, frequency and duration specified in the service plan. Numerator = Number of participants who received services in the scope, amount, frequency and duration specified in the service plan; Denominator = Total number of participants.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.a.i.d.1 Number and percent of participants who received all types of services specified in the plan of care. Numerator = Number of participants who received all types of services specified in the plan of care; Denominator = Total number of participants.

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

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

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Medicaid data contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
D.a.i.e.3 Number and percent of waiver participants with a valid signature, defined as the participants/authorized representative's signature, on the service plan which verifies they were offered choice between traditional or participant directed service options. Numerator= Number of participants with a valid signature on the service plan; Denominator = Total # of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
D.a.i.e.2 Number and percent of waiver participants with a valid signature, defined as the participants/authorized representative's signature, on the service plan which verifies that a list of waiver services was provided to and discussed with the waiver participant. Numerator = number of participants with a valid signature on the service plan; Denominator = number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

For all performance measures except D.a.i.c.1, D.a.i.d.1 and D.a.i.d.2 OAAS Regional Office (RO) staff performs monitoring of Support Coordination Agencies (SCAs) at least annually utilizing the OAAS Support Coordination Monitoring Tools: Participant Interview, Participant Record Review, Support Coordinator Interview, and Agency Review. The sample size will be large enough for a confidence level of 95% and will be designated on the first day of each waiver year. The number of participants from the statewide sample to be included in each SCA sample will be proportional to the percentage of participants linked to each agency on the first day of each waiver year. An SCA's sample size will be determined separately for each region in which the SCA operates.

For all performance measures except D.a.i.c.1, D.a.i.d.1 and D.a.i.d.2., the specific criteria for these measures are found in the OAAS Interpretive Guidelines for the OAAS Participant Record Review.

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

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

Regarding D.a.i.d.1 and D.a.i.d.2: The data contractor prior authorizes services according to the approved service plan and enters post authorization of service once a provider has verified service delivery. This data is utilized to determine whether the participant received the type, scope, amount, duration, and frequency specified in the service plan. The SMA and the Operating agency review the quarterly reports for these measures.

Regarding D.a.i.e.1, D.a.i.e.2,and D.a.i.e.3 a valid signature on the service plan is either the signature of a participant with the capacity to approve the plan or a person who has been designated on the OAAS Authorized Representative form as such.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The State's method for addressing individual problems identified through performance measures D.a.i.c.1., D.a.i.d.1., D.a.i.d.2 is as follows:

D.a.i.c.1: The OAAS RO receives quarterly reports from the data contractor for review. If the participant's annual Plan of Care (POC) was not submitted within the required timeline, RO will contact the SCA. The SCA will have 10 days to correct the discrepancies. If the corrections are not made within the timeframe, and depending upon the scope and persistence of such problems, OAAS may pursue sanctions as outlined in the Support Coordination Agency Performance Agreement including withholding payment.

D.a.i.d.1: The OAAS RO receives quarterly reports from the data contractor in order to review trends and patterns of under-utilization of services. If this appears to be an isolated event, RO will follow up with the SCA to determine the reason and the SC shall revise the POC as necessary. If the POC Revision is not submitted within the time frame, OAAS shall pursue sanctions as outlined in the Support Coordination Agency Performance Agreement. If this appears to be widespread, RO will consult with State Office staff who will then bring the issue to the OAAS Quality Review Team and, if necessary, the OAAS Executive Management Team for review and resolution.

D.a.i.d.2: The OAAS RO receives quarterly reports from the data contractor in order to review trends and patterns of under-utilization of services. If the RO discovers under-utilization due to a particular agency, among certain services, lack of availability of services, etc., RO will consult with State Office staff who will then bring the issue to the OAAS Quality Review Team and if necessary, OAAS Executive Management Team for review and resolution.

The remediation activities for these three measures will be documented in a spreadsheet by RO.

The State's method for addressing individual problems identified through the remaining performance measures is as follows: RO staff performs monitoring of Support Coordinator Agencies (SCAs) at least annually utilizing the following OAAS Support Coordination Monitoring Tools: Participant Interview; Participant Record Review; Support Coordinator Interview; and Agency Review. The processes for scoring and determining the necessity for corrective actions are located in the Support Coordination Agency Monitoring Policy and Procedures Manual. After all elements are assessed and scored, the RO reviewer documents the findings, including the Statement of Determination which delineates every POC remediation required and required responses/plans of correction expected from the SCA. Based on the scope and severity of findings, the SCA is assigned a Statement of Determination at Level I, Level II, or Level III. RO and/or State Office follow-up according to timelines associated with each level to ensure that plans of correction are implemented and effective. Level III determinations are those having the actual or potential to immediately jeopardize the participant's health and safety. In these cases, the SCA must develop a plan of correction that includes the identification of the problem; full description of the underlying causes of the problem; actions/interventions that target each underlying cause; responsibility, timetable, and resources required to implement interventions; measurable indicators for assessing performance; and plans for monitoring desired progress and reporting results. In addition, OAAS takes immediate enforcement action to assure the health and safety of participants. Actions include, but are not limited to: transfer of participants who are/may be in jeopardy; removal of SCA from the freedom of choice list; suspension of all new admissions; financial penalties; and suspension of

contract/certifications as a provider of SC services.

If a Plan of Correction, Progress Report and/or Follow-up Report remains unapproved by the time of the next annual review, the agency is placed on the next level with more stringent requirements. With a finding of satisfactory or a recommendation for improvement, no remediation is required. These remediation activities will be documented through tracking events in the Support Coordination Monitoring database.

Training will be necessary when trends are detected in POCs that do not address: participant goals, needs (including health care needs), and preferences; how waiver and other services are coordinated; and identification of responsibilities to implement the plan. The training requirements depend on the Support Coordination Monitoring findings and are based on the criteria found in the OAAS Interpretive Guidelines for the OAAS Participant Record Review.

An unsatisfactory plan of care is one with criteria "not met" according to the OAAS Interpretive Guidelines for the OAAS Participant Record Review.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

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

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

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

◉ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

○ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

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

☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

○ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

To be eligible, the participant must:

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

- Complete the training programs (e.g. initial enrollment training) designated by OAAS.

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

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

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

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

This training also includes a discussion on the differences between Self-Direction versus services delivered by a provider agency (which includes the benefits, risks, and responsibilities associated with each service option) and the roles and responsibilities of the employer, support coordinator, and fiscal/employer agent.

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

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

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

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

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

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

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

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

- Effectuate the decision the participant would make for himself/herself;
- Accommodate the participant, to the extent necessary that they can participate as fully as possible in all decisions that affect them;
- Give due consideration to all information including the recommendations of other interested and involved parties; and
- Embody the guiding principles of self-determination.

A participant may designate any person 21 years of age or older as an authorized representative unless a legal representative has been designated by a court or is otherwise limited by existing or pending legal action prohibiting someone from serving as an authorized representative.

An authorized representative may not receive payment for functioning as an authorized representative, nor may they receive payment for any waiver service provided to support the participant.

The support coordinator must recognize the participant's authorized representative as a decision-maker, and provide the authorized representative with all of the information, training, and support the support coordinator would typically provide to a participant who is self-directing. The support coordinator must fully inform the authorized representative of the rights and responsibilities of an authorized representative in accordance with established procedures. The support coordinator must have the authorized representative review and sign a standard agreement form, which must be given to the authorized representative and maintained by the support coordinator. The agreement lists the roles and responsibilities of the authorized representative; asserts that the authorized representative accepts the roles and responsibilities of this function; and asserts that the authorized representative will abide by Medicaid Waiver policies and procedures.

Service plan monitoring takes place with each participant. Several questions on the standard service plan monitoring tool can prompt the identification of any issues with the authorized representative not acting in the best interest of the participant. Issues noted on the monitoring tool are addressed by Support Coordinators and OAAS.

The support coordinator is required to address and report any issues identified with the authorized representative's performance including but not limited to compliance to Medicaid Waiver policies on incident reporting and report any incident of suspected fraud or abuse.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Waiver Service	Employer Authority	Budget Authority
Personal Assistance Services (PAS)	☒	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

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

☐ **Governmental entities**

☒ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

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

The waiver service entitled:

Financial Management Services

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

Provide the following information

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

Fiscal Management Services are provided by a Medicaid enrolled fiscal/employer agency.

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

Fiscal Management Service entity bills services monthly to the Fiscal Intermediary.

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

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

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

☐ **Maintain a separate account for each participant's participant-directed budget**

☐ **Track and report participant funds, disbursements and the balance of participant funds**

☐ **Process and pay invoices for goods and services approved in the service plan**

☐ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

Specify:

Additional functions/activities:

☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☐ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

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

If the participant decides that he/she would like to participate in this option, the support coordinator shall notify the OAAS Regional office and the Self-Direction Program Manager. Once notified by OAAS Regional office that the participant is eligible to participate in Self-Direction, the Support Coordinator facilitates the scheduling of the initial Self-Direction planning meeting. Freedom of choice of FMS providers is offered to the waiver participant/authorized representative during this planning meeting.

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

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

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

☒ **Waiver Service Coverage.**

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Housing Stabilization Services	☐
Transition Service	☐
Assistive Devices and Medical Supplies	☐
Caregiver Temporary Support Service	☐
Financial Management Services	☐
Support Coordination	☒
Environmental Accessibility Adaptation	☐
Adult Day Health Care	☐
Skilled Maintenance Therapy	☐
Nursing	☐
Monitored In-	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Home Caregiving	
Personal Assistance Services (PAS)	☐
Housing Transition or Crisis Intervention Services	☐
Home Delivered Meals	☐
Assistive Technology	☐
Transition Intensive Support Coordination	☐

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

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

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

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

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

All waiver participants have access to independent advocacy through the Disability Rights Louisiana (formerly the Advocacy Center)in Louisiana.

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

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

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

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

Involuntary termination may occur for the following reasons:

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

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

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

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

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

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

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

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

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

- If there is proof of misuse of public funds.

When action is taken to terminate a participant from Self-Direction involuntarily, the Support Coordinator immediately assists the participant in accessing needed and appropriate services through the Community Choices Waiver and other available programs, ensuring that no lapse in necessary services occurs for which the participant is eligible. There is no denial of services, only the transition to a different payment option. The participant and Support Coordinator are provided with a written notice explaining the reason for the action and citing the policy reference.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	243	
Year 2	364	
Year 3	499	

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 4	499	
Year 5	499	

Appendix E: Participant Direction of Services

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

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

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

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

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

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

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

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Criminal background checks are conducted by the Fiscal Employer Agent and results are shared with the employer. The cost of criminal background checks are a component of the FMS rate methodology.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

As referenced in C-2a, the FEA provider is responsible for assuring that Medicaid exclusion checks, are conducted on all prospective self-direction employees. Once the FEA provider verifies that the employee has cleared the background check and successfully completed all enrollment activities, the employee is approved to provide services.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

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

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

☐ **Reallocate funds among services included in the budget**

☐ **Determine the amount paid for services within the state's established limits**

☐ **Substitute service providers**

☐ **Schedule the provision of services**

☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☐ **Identify service providers and refer for provider enrollment**

☐ **Authorize payment for waiver goods and services**

☐ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

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

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

1. Denial of entrance into a home and community-based service waiver;
2. Involuntary reduction or termination of a support or service;
3. Discharge from the system; and/or
4. Other cases as stated in office policy or as promulgated in regulation.

During the initial assessment process, which must begin within ten (10) business days of referral/linkage of the participant to the Support Coordination Agency (SCA), the Support Coordinator (SC) will give a participant and/or his/her legal representatives an OAAS information sheet entitled “Rights and Responsibilities for Applicants/Participants of a Home and Community-Based Services Waiver” which includes information on how to file a complaint, grievance or appeal.

The SC and/or RO are responsible for giving written adverse action notices to the individual and/or his/her legal representatives of how to contact the DAL section.

BHSF utilizes the Home and Community-Based Services (Waiver) Medicaid Decision notice to notify individuals by mail if they have not been approved for a Home and Community-Based Services Waiver due to financial ineligibility. Page two (2) of this notice includes "Your Fair Hearing Rights". This page contains information on how to request a fair hearing and a section to complete, if the individual is requesting a fair hearing. This written adverse action notice to the waiver participant indicates that this decision is a Medicaid decision. If the participant does not return this form, it does not prohibit his right to appeal and receive a fair hearing.

In accordance with 42 CFR 431.206, 210 and 211, participants receiving waiver services, and their legal representatives are sent a letter by OAAS Regional Office (RO) providing at least ten (10) days advance and adequate notification of any proposed denial, reduction, or termination of waiver services. Included in the letter are instructions for requesting a fair hearing, and notification that an oral or written request must be made to the Division of Administrative Law (DAL) on or before the date of the proposed adverse action by the RO in order for current waiver services to remain in place during the appeal process. If the appeal request is not made to DAL on or before the date of the proposed adverse action, but is made within thirty (30) days from the date of the notice, the action is taken pending final outcome of the appeal. If the final decision of the Administrative Law Judge (ALJ) is favorable to the appellant, services are reinstated from the date of the final decision. An appeal hearing is not granted if the appeal request is made later than thirty (30) days following the date of the notice sent by RO. Once a request for an appeal is received, DAL notifies RO of the appeal request. A copy of the letter and the appeal request is kept in the participant’s record at the appropriate RO. A final decision must be rendered within ninety (90) calendar days of the appeal request.

In the event of an appeal request, if requested by the participant and/or legal representative, the SC will provide documentation (e.g. progress notes, etc.) and information that may be necessary to complete the appeal or prepare for a fair hearing. In addition, at a fair hearing, the SC will participate by telephone.

Anyone requesting an appeal has the right to withdraw the appeal request at any time prior to the hearing. The appellant may contact the DAL directly, or may request withdrawal through the RO. Requests for withdrawal are kept in the participant’s record at the appropriate RO.

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.

OAAS will provide MPSW with quarterly reports of those individuals who have been notified of appeal rights when waiver services have been denied, terminated or reduced, reasons for the appeal and the outcome of the appeal.

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**

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

The Health Standards Section (HSS) is responsible for operating a HCBS complaint line to address complaints concerning all LDH/HSS licensed waiver providers. OAAS is responsible for addressing complaints concerning Support Coordination Agencies (SCAs).

• **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).

For purposes of this application, the words “"complaints"” and “"grievances"” are used interchangeably.

LDH does not restrict the types of grievances that participants may register. In the Rights and Responsibilities form that every participant receives is the telephone number of the OAAS Help Line and the HSS complaint line to call in complaints.

1. HSS retains responsibility for licensing those waiver providers for whom licensing is required. Their complaint process is described below:

It is the policy of HSS to assess, report, investigate and follow-up on all complaints involving licensed waiver providers. HSS will investigate and/or refer complaints to the appropriate agency relative to a participant not receiving care and/or treatment for which he/she is entitled under State or Federal laws. Investigations occur as soon as possible after intake. Complaints are triaged into two (2), ten (10)or thirty (30) calendar days depending on the severity of the allegation. When deficiencies are cited relative to the complaint investigation, the provider is required to submit a plan of correction within ten (10) business days. After the plan of correction is reviewed and determined acceptable, a provider is given up to sixty (60) calendar days to implement corrective action. A revisit is conducted either on-site or by desk review to verify that the plan of correction has been implemented.

The length of time for deficiencies to be cited is dependent upon when the survey is completed. A complaint triaged as immediate jeopardy (to initiate investigation within two (2) business days) will have deficiencies written sooner than one triaged as a thirty (30) calendar day complaint. If a thirty (30) calendar day triage is assigned, the HSS field office has thirty (30) calendar days from the date of the complaint intake to enter the provider agency. If it is found that the client is indeed in an immediate jeopardy situation, HSS will require a plan of removal so that the immediacy of the situation is removed for the client and imminent peril or harm no longer exists. This is different from a plan of correction for deficiencies that may be cited. When an incident has occurred, the provider agency is responsible for doing its own internal investigation. If HSS also receives a complaint, then HSS is required by law to investigate. In cases of abuse or neglect involving home and community-based services, Protective Services also investigates. HSS receives copies of all these reports and if there is anything regulatory involved, may initiate a complaint investigation.

2. OAAS retains responsibility for certifying OAAS Support Coordination Agencies (SCAs). OAAS requires SCAs to have a grievance process that allows all participants to freely voice any and all complaints. A copy of the SCA complaint and/or grievance process is provided to each participant. The SCA must first investigate to determine if the participants' complaints can be resolved internally. The SCA is responsible for working with the participant regarding the complaint. If the participant is not satisfied with the SCA's resolution, the SCA is required to notify OAAS. It is the policy of OAAS to immediately assess, report, investigate and follow-up on all complaints about SCAs involving OAAS waiver participants as soon as they are received. The participant may also report any complaints regarding their SCA to OAAS.

All participants are informed that filing a grievance or making a complaint is not a pre-requisite or substitute for a fair hearing.

OAAS staffs a Help Line that gives participants the ability to file any and all other complaints not related to licensed service providers or SCAs.

By establishing the complaint system identified above, the participants, Support Coordinators (SCs), providers, and general public have a means by which to report any and all complaints that may influence the care or services a participant receives.

All complaints involving abuse, neglect, exploitation and extortion of waiver participants must immediately be forwarded to Protective Services and/or law enforcement, as appropriate, and copied to LDH State Office and ROs through the critical incident management system. The providers and/or SCAs must cooperate with external agencies: Protective Services and law enforcement, by providing relevant information, records, and access.

OAAS State Office (SO) staff works collaboratively with OAAS ROs to review complaints and assess whether any changes to policies, procedure, etc. are warranted based on the findings. Additionally, through annual SCA Review Monitoring, OAAS staff ensures that SCAs are documenting complaints and following the policies set forth by each individual agency in accordance with OAAS requirements.

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).

It is the policy of OAAS to assess, investigate, report, and follow-up on all critical incidents involving all Community Choices (CC) Waiver participants. When an event is considered critical, the provider must immediately ensure the health and welfare of the participant and complete a LDH HCBS Critical Incident Report. The provider and/or the Support Coordination Agency (SCA) must report critical incidents within two (2) hours of first knowledge of the incident. The provider is required to complete and submit the HCBS Critical Incident Report within 24 hours of discovery of the incident and must provide an update to the SCA within three (3) working days.

Types of OAAS critical incidents or events that must be reported include:

A. Major Injury - any suspected or confirmed wound or injury to a person of known or unknown origin which requires treatment by a physician, dentist, nurse, or other licensed health care provider.

B. Major Medical Event - an occurrence in which the participant receives a medical procedure by a physician, nurse practitioner, dentist, or other licensed health care provider either during an inpatient or outpatient visit, and a new diagnosis is identified or new orders for medications, services, (such as Home Health), therapy, equipment, health-related tasks, or treatments are prescribed.

C. Death - all deaths of participants are reportable, regardless of the cause or the location where the death occurred.

D. Falls - when the person is (1) found down on the floor (un-witnessed event) or (2) comes to rest on the floor unintentionally, whether or not the person is being assisted at the time.

E. Major Medication Incident - means the administration of medication in an incorrect form, not as prescribed or ordered, or to the wrong person, or the failure to administer a prescribed medication, which requires treatment by a physician, nurse, dentist or any licensed health care provider. Medication errors may be due to the following:

1. Staff error - the staff fails to administer a prescribed medication, or administers the wrong medication or dosage to a person; staff failure to fill a new prescription order within 24 hours or a medication refill prior to the next ordered dosage.
2. Pharmacy error - the pharmacy dispenses the wrong medication and/or dose or provides inaccurate or inappropriate administration directions.
3. Participant error - the person unintentionally fails to take his/her medication as prescribed.
4. Family error - a family member intentionally or unintentionally fails to administer a prescribed medication or fails to fill a new prescription order.

F. Major Behavioral Incident - the occurrence of an incident that can reasonably be expected to result in harm or may affect the safety and well being of the person. The following are examples of major behavioral incidents: attempted suicide, suicidal threats, self endangerment, elopement, self injury, and physical aggression. Offensive sexual behavior and sexual aggression are considered reportable if it is a new behavior which is not addressed in the POC, or if there has been an increase in the intensity or frequency of the behavior.

G. Involvement with Law enforcement resulting in participant's arrest

H. Participant is a victim of crime

I. Loss or Destruction of Home - damage to or loss of the participant's home that causes harm or the risk of harm to the participant. This may be the result of any action, man-made or natural. Examples include fire, flooding, eviction, unsafe or unhealthy living environment.

Protective Services Critical incidents shall be reported by 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 and shall report to the adult protection agency or to law enforcement. (Louisiana Revised Statute 14:403.2)

Types of Protective Services critical incidents or events that must be reported include:

A. Abuse

1. Physical - contact or actions that result in injury or pain, such as hitting, pinching, yanking, shoving,

pulling hair, etc.
2. Emotional - threats, ridicule, isolation, intimidation, harassment
3. Sexual abuse of an adult, when any of the following occur:
   a. the adult is forced, or otherwise coerced by a person into sexual activity or contact,
   b. the adult is involuntarily exposed to sexually explicit material, sexually explicit language, or sexual activity or contact;
   c. the adult lacks the capacity to consent, and a person engages in sexual activity or contact with that adult.

B. Neglect
1. Care Giver - means withholding or not assuring provision of basic necessary care, such as food, water, medical, or other support services, shelter, safety, reasonable personal and home cleanliness or any other necessary care.
2. Self - means failing, through one's own action or inaction, to secure basic essentials such as food, medical care, support services, shelter, utilities or any other care needed for one's well-being.

C. Exploitation - the misuse of someone's money, services, property, or the use of a power of attorney or guardianship for one's own purposes

D. Extortion - taking something of value from a person by force, intimidation, or abuse of legal or official authority.

The direct service provider must report critical incidents, including abuse & neglect, within 2 hours of first knowledge of the incident.

Incidents of abuse, neglect, exploitation and extortion must be reported to the SC and to Protective Services.

When an incident is discovered by the SC, the SC must contact the DSP within 2 hours of discovery. When abuse, neglect, exploitation or extortion is discovered by the SC, the SC must contact Protective Services.

LDH/OAAS informs participants of their right to be free from restraints and seclusion through the Rights and Responsibilities form. Support coordinators (SCs) are trained by OAAS to identify, detect, and regularly monitor for evidence of use of restraints and seclusion. They are also trained to help participants explore alternatives to the use of restraints and how to properly report suspected use.

The SC monitors participants through monthly telephone contact and quarterly contacts to ensure that these rights are maintained. During OAAS' annual Support Coordination Monitoring, OAAS staff confirms that SCs both monitor and address any identified instances of restraints in accordance with OAAS policy through its annual record review process. Oversight of other licensed providers is conducted through LDH's Health Standards Section (HSS).

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

The participant and/or his/her responsible representative are given information pertaining to abuse, neglect, and exploitation by review of the Rights and Responsibilities form with the SC at the initial, and annual meetings.

The Protective Services toll-free Help Line telephone number for persons to report abuse, neglect, or exploitation are printed on the Rights and Responsibilities form and LDH web-site.

The purpose of the OAAS Help Line is to provide a central point of communication in Louisiana for individuals inquiring about all aspects of home and community-based services. It also provides a central point to contact LDH about incidents involving services, personal treatment, health and welfare. The OAAS Help Line telephone number is printed on the Rights and Responsibility form and LDH web-site.

OAAS RO telephone numbers are also provided to the participants and the public to inquire about all aspects of home and community-based services and to provide information about incidents involving services, personal treatment, health and welfare.

In relation to critical incidents, the Rights and Responsibilities form explains that participants have the right to be treated with dignity and respect, to be free from abuse, neglect and exploitation and provides the telephone number to report suspected cases of abuse, neglect and exploitation. This form also explains that individuals have the responsibility to report critical incidents including, abuse, neglect, exploitation, or extortion, to their SC and direct service provider immediately. There is no limit on the amount of time which a participant has to report a critical incident. It further explains that the support coordinator should be made aware of any of the following changes: health, medications and physical condition and that he/she will assist in reporting and resolving critical incidents.

SCs are required to educate individuals during initial and annual POC meetings on the information described above.

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 responsibility for review of and response to critical incidents is a collaboration between Direct Service Providers (DSPs), SCs and OAAS RO staff with OAAS assuming the primary responsibility for assuring that all health and welfare follow-up has been accomplished. OAAS RO staff monitors the progress of each incident and the work of the SC and the DSP to ensure each incident report is complete and submitted timely. Once the RO staff verifies the completeness of the report, the RO manager or designee conducts their review and makes the final determination as to whether all appropriate actions have been taken to protect the participant from harm, to ensure all medical or other services were provided, and that the service plan identifies possible measures to prevent or mitigate the recurrence of similar critical incidents. The responsibilities are further delineated as follows:

A. DSP responsibilities:

1. Take immediate action to assure the participant is protected from further harm and respond to any emergency needs of the participant;
2. Report incidents involving abuse, neglect, exploitation, and extortion to Protective Services.
3. Notify the support coordination agency within two (2) hours of discovery of the occurrence of the critical incident.
4. Cooperate with the investigation/incident and provide all necessary information/documentation, at a minimum, by close of the third business day after the initial report;
5. Submit updates to the support coordination agency regarding the critical incident, as necessary, until resolution, including, at a minimum, by the close of the third business day of the initial report;
6. Submit updates in the CIR system regarding the critical incident, as necessary, until resolution, including, at a minimum, at least one update submitted by the close of the third business day of the initial report;
7. Participate in any planning meetings convened to resolve the critical incident or to develop strategies to prevent or mitigate the likelihood of similar critical incidents occurring in the future;
8. In the event of falls, conduct a fall assessment using the OAAS Fall Assessment Form and submit with initial Critical Incident Report; subsequently conduct a fall analysis and complete the OAAS Fall Analysis and Action Form and submit with Follow-up information; and
9. Track critical incidents to identify remediation needs and quality improvement goals and to determine the effectiveness of the strategies employed.

B. Support Coordination Agency (SCA) responsibilities:

1. Take immediate action to assure the participant is protected from further harm and respond to any emergency needs of the participant;
2. When the incident is discovered by the SC, contact the DSP, within two (2) hours of discovery and enter the critical incident in the CIR system;
3. Report incidents involving abuse, neglect, exploitation, and extortion to the appropriate protective services agency;
4. Enter critical incident report information into the LDH critical incident reporting database by close of business the next business day after notification of a critical incident;
5. Enter follow-up case note by close of the sixth business day after initial report;
6. Continue to follow up with the DSP, the participant, and others, as necessary, and update the LDH critical incident reporting system with case notes until the incident is resolved and the case is closed;
7. Convene any planning meetings that may be needed to resolve the critical incident or develop strategies to prevent or mitigate the likelihood of similar critical incidents occurring in the future and revise the POC accordingly;
8. Send the participant and DSP a copy of the Incident Participant Summary within fifteen (15) days after Final Supervisory Review and Closure by the RO. It does not include the identity of the reporter or any sensitive or unsubstantiated allegations. The Participant Summary is not distributed in the event of deaths;
9. In the event of falls, ensure that a fall assessment is conducted using the OAAS Fall Assessment form and a fall analysis using the OAAS Fall Analysis and Action form; reviews analysis and collaborates with the DSP and natural supports to implement preventative strategies;
10. Track critical incidents to identify remediation needs and quality improvement goals and to determine the effectiveness of strategies employed.

C. OAAS Regional Office (RO) Manager (or designee) responsibilities:

1. On a daily basis, review all new critical incidents including protective services cases. Determine priority level (urgent or non-urgent) of cases and assign to RO staff. Priority is based on the information received, the severity of the incident, when the incident occurred, and when the incident report was received. The OAAS RO staff determines whether the incident is urgent or non-urgent. Investigation will be prioritized as follows:
   - Urgent - any event or situation that creates a significant risk of substantial harm to the physical or mental health, safety, or well being of a waiver participant;
   - Non-urgent - all other events/situations
2. Alert staff members of urgent cases within one (1) business day of receipt of the incident and take appropriate action;
3. Review and approve extension requests made by RO staff (extensions may be granted up to 30 calendar days at a time). Extensions should not exceed 90 days unless it is an protective services case in which case extensions should not exceed 150 calendar days.
4. Assure that all mandatory fields are entered into the LDH critical incident reporting system prior to case closure;
5. Close cases after all needed follow-up has occurred and all necessary data has been entered into the LDH critical incident reporting database (Final Supervisory Review and Closure).
6. Track critical incidents to identify remediation needs and quality improvement goals and to determine the effectiveness of strategies employed.

D. OAAS Regional Office (RO) Staff responsibilities:

1. Continue to follow up with the support coordination agency, provide technical assistance, and request additional information in writing as necessary until closure of the critical incident;
2. Make timely referrals to other agencies as necessary;
3. Assure that all necessary information is entered into the LDH critical incident reporting database by SCA;
4. Assure that activities occur within required timelines, including closure of the incident within 30 days unless an extension has been granted;
5. Submit requests for extensions to the RO Manager for review and approval;
6. Assure that the Incident Participant Summary is completed on all cases, including Protective Services cases; and
7. Identify participants who experience frequent critical incidents and work with the SCA to identify and develop strategies to mitigate risk.

The following agencies may be requested to assist and/or respond to critical incidents:
- APS - for incidents regarding abuse, neglect, and/or exploitation and/or extortion of participants age 18 to 59;
- EPS - for incidents regarding abuse, neglect and/or exploitation and/or extortion of participants age 60 and over;
- Attorney General - when incidents are determined valid following an investigation by OAAS and/or another agency;
- Law enforcement - for incidents involving allegations of sexual and/or physical abuse and suspected criminal activity;
- LDH Program Integrity - for incidents related to billing irregularities and/or
- LDH Health Standards Section (HSS) - handles reports for people who reside in a public or private Intermediate Care Facility for persons with Developmental Disabilities (ICFs/DD), ICF/Nursing Facilities, and for protective services cases in which the alleged perpetrator is an employee of an agency licensed by HSS (e.g. an employee of a personal care attendant agency).

Appropriate action means that the participant is protected from harm, all medical or other services were provided and that the service plan identifies possible measures to prevent or mitigate the recurrence of similar critical incidents. These actions are further delineated under Appendix G-1.d.

Please refer to G-1.d section B.8: Send the participant and DSP a copy of the Incident Participant Summary within fifteen (15) calendar days after final supervisory review and closure by the RO.

The required timeline including closure of the incident is 30 calendar days unless an extension has been granted as described in Appendix G-1.d.

As defined in the OAAS Critical Incident Policy (OAAS-ADM-10-020), the definition of an extension is: Additional time allowed for completion and closure of a critical incident. Extensions are approved by the RO Manager or designee

when additional time is needed to respond to the incident. Primary examples include hospitalizations, temporary admission to a long term care facility, or awaiting a protective services report. Extensions shall not be granted for more than 30 calendar days at a time. Extensions should not exceed 90 calendar days with the exception of protective services cases in which extensions shall not exceed 150 calendar days.

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.

OAAS shall collaborate with Direct Service Providers (DSPs), Support Coordination Agencies (SCAs)and Protective Services to ensure the implementation of critical incident procedures to accomplish the following goals:

A. Assure that the participant is protected from further harm and that medical or other services are provided, as needed.
B. Complete incident report and assure that the information is entered and monitored in the LDH critical incident reporting database.
C. Continue to follow-up to determine the cause and details of the critical incident.
D. Convene the participant's support team, when appropriate, to review the Plan of Care (POC)/service plan to identify possible measures to prevent or mitigate the re-occurrence of similar critical
incidents.
E. Revise the POC/service plan, as indicated, and monitor the effectiveness of the revised plan.
F. Close the critical incident in the critical incident management system.
G. Inform the participant and other relevant parties of the investigation results.

Protective Services Cases

Incidents involving abuse, neglect, extortion, or exploitation of participants age 18-59 will be reported to Adult Protective Services (APS). Those aged 60 and over are reported to Elderly Protective Services unless the allegation involves the accusation of a paid provider, in which case the referral is taken by APS and referred to Health Standards. Incidents accepted by Protective Services are investigated and entered into a critical incident reporting database by Protective Services. Protective Services is responsible for investigations involving non-licensed individuals and LDH's Health Standards Section (HSS) is responsible for investigations involving licensed providers. RO cooperates with the investigation. Upon Protective Services closure the case is transferred to RO to complete any actions or recommendations to assure health and welfare. Upon closure by the RO, the participant is sent a summary of the incident.

OAAS State Office (SO) Responsibilities:
1. Provide technical assistance to RO staff, as needed.
2. Identify statewide needs for training regarding: (a) response to critical incidents; (b) adherence to the critical incident policy; (c) correct entry of critical incident data; (d) tracking critical incidents; (e) using data for remediation and/or quality enhancement; and (f) other related topics.
3. During the Support Coordination Monitoring Record Review process, a statistically valid sample of critical incidents are reviewed for adherence to policy, analysis of actions taken to address/resolve the critical incident, analysis of non-resolved cases, and other pertinent issues as determined. Following the monitoring period, State Office staff analyzes the monitoring data to identify areas in need of reinforcement, technical assistance, and remediation.
4. Aggregate critical incident data quarterly and analyze the data to identify trends and patterns.
5. Generate and review reports of the trends and patterns to identify potential quality enhancement goals.
6. Conduct an annual analysis of data to determine the effectiveness of quality enhancement goals and activities.

Medicaid provides oversight of critical incident management through the Medicaid HCBS Oversight Committee which meets quarterly to review current performance reports for all waiver assurances including health and welfare.

Appendix G: Participant Safeguards

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

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

regarding seclusion appear in Appendix G-2-c.)

◉ **The state does not permit or prohibits the use of restraints**

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

LDH/OAAS informs participants of their right to be free from restraints and seclusion through the Rights and Responsibilities form. Support Coordinators(SCs) are trained by OAAS to identify, detect, and regularly monitor for evidence of use of restraints and seclusion. They are also trained to help participants explore alternatives to the use of restraints and how to properly report suspected use.

The SC monitors participants through monthly telephone contact and quarterly contacts to ensure that these rights are maintained. During OAAS' annual Support Coordination Monitoring, OAAS staff confirms that SCs both monitor and address any identified instances of restraints in accordance with OAAS policy through its annual record review process. Oversight of other licensed providers is conducted through LDH's Health Standards Section (HSS).

The Protective Services toll free lines and LDH/OAAS critical incident reporting process provides mechanisms for reporting, communicating, and responding to violations of these rights.

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

LDH/OAAS informs participants of their right to be free from restrictive interventions through the Rights and Responsibilities form. Support Coordinators(SCs) are trained by OAAS to identify, detect, and regularly monitor for evidence of use of restrictive interventions. They are also trained to help participants explore alternatives and how to properly report suspected use.

The SC monitors participants through monthly telephone contact and quarterly contacts to ensure that these rights are maintained. During OAAS' annual Support Coordination Monitoring, OAAS staff confirms that SCs both monitor and address any identified instances of restrictive interventions in accordance with OAAS policy through its annual record review process. Oversight of other licensed providers is conducted through LDH's Health Standards Section (HSS).

The Protective Services toll free lines and LDH/OAAS critical incident reporting process provides mechanisms for reporting, communicating, and responding to violations of these rights.

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

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

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

Appendix G: Participant Safeguards

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

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

◉ **The state does not permit or prohibits the use of seclusion**

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

LDH/OAAS informs participants of their right to be free from seclusion through the Rights and Responsibilities form. Support Coordinators(SC) are trained by OAAS to identify, detect, and regularly monitor for evidence of participant seclusion. They are also trained to help participants explore alternatives and how to properly report suspected use.

The SC monitors participants through monthly telephone contact and quarterly contacts to ensure that these rights are maintained. During OAAS' annual Support Coordination Monitoring, OAAS staff confirms that SCs both monitor and address any identified instances of participant seclusion in accordance with OAAS policy through its annual record review process. Oversight of other licensed providers is conducted through DHH's Health Standards Section (HSS).

The Protective Services toll free lines and LDH/OAAS critical incident reporting process provides mechanisms for reporting, communicating, and responding to violations of these rights.

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

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

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

◉ **No. This Appendix is not applicable** *(do not complete the remaining items)*

○ **Yes. This Appendix applies** *(complete the remaining items)*

- **Medication Management and Follow-Up**

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

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices

(e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

• **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).

• **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:

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Performance Measures

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

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

Performance Measure:
G.a.i.a.1. Number and percent of abuse, neglect, exploitation, and unexplained death investigations that included evidence of effective resolution and preventative measures. Numerator = Number of investigations that included evidence of effective resolution and preventative measures; Denominator = All investigations completed and transferred to waiver staff

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
G.a.i.b.2 Number and percent of participants with a valid signature, defined as the participant's/authorized representative's signature, on the service plan which verifies receipt of information about how to report critical incidents as specified in the approved waiver. Numerator = # of participants with a valid signature on the service plan; Denominator= Total # of participants reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G.a.i.b.1 Number and percent of critical incident reports that were completed within required time frames as specified in the approved waiver. Numerator = Number critical incident reports that were completed within required time frames as specified in the approved waiver; Denominator = Total number of critical incidents reports.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
G.a.i.c.1 Number and percent of participants with a valid signature, defined as the participant's/authorized representative's signature, on the service plan which verifies receipt of information on how to remain free from restraints and seclusion. Numerator=Number with a valid signature on the service plan which verifies receipt of information; Denominator=Total number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

		Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based***

on the responsibility of the service provider as stated in the approved waiver.

Performance Measures

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

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

Performance Measure:
G.a.i.d.1 Number and percent of participants who received the coordination and support to access health care services identified in their service plan. Numerator = Number of participants who received the coordination and support to access health care services identified in their service plan; Denominator = Total number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

It is the policy of OAAS to assess, investigate, report, and follow-up on all critical incidents involving all Community Choices Waiver participants. When an event is considered critical, the direct service provider (DSP) and/or support coordinator will be required to immediately ensure the health and welfare of the participant and will be required to complete the LDH HCBS Critical Incident Report Form. The DSP and/or the support coordination agency will be required to report critical incidents within two (2) hours of first knowledge of the incident.

In reference to G.a.i.a.1, OAAS State Office staff will review each finalized protective services investigation after it is transferred to OAAS Regional Office staff and closed. This review will confirm whether each incident included evidence of effective resolution and preventative measures as recommended by protective services.

In reference to G.a.i.b.1, the required timeline, including closure of the incident, is 30 calendar days unless an extension has been granted as described in Appendix G-1-d. As defined in the OAAS Critical Incident Policy OAAS-ADM-10-020, the DSP or support coordinator must report critical incidents, including abuse & neglect, within 2 hours of first knowledge of the incident. The OAAS Regional Office staff is responsible for monitoring each incident to make sure that it is closed timely and complete.

In reference to G.a.i.b.2, G.a.i.c.1, and G.a.i.d.1, OAAS regional office staff perform monitoring of support coordination agencies at least annually utilizing the OAAS Support Coordination Monitoring Tools:

- Participant Interview;
- Participant Record Review;
- Support Coordinator Interview; and
- Agency Review.

The sample size will be large enough for a confidence level of 95% and will be designated on the first day of each waiver year. The number of participants from the statewide sample to be included in each support coordination agency (SCA) sample will be proportional to the percentage of participants linked to each agency on the date the sample is generated. A SCA's sample size will be determined separately for each region in which the SCA operates.

In reference to G.a.i.b.2, G.a.i.c.1, the Rights and Responsibilities form informs participants of:
1. Their right and responsibility to report critical incidents to their support coordinator and DSP and of their right to report suspected abuse, neglect and exploitation by calling Protective Services; and
2. Their right to remain free from all types of restraints and seclusion.

The support coordinator provides information to the participant which aids in identifying restraint use and seclusion and also provides instruction for the participant to report this to their support coordinator. The support coordinator will then provide technical assistance and implement alternative measures that are the least restrictive to the participant (e.g. personal assistance devices, DME, etc.). The support coordinator reviews this information with the participant and/or authorized representative each year during the service plan development meeting. A valid signature on the service plan is either the signature of a participant with the capacity to approve the plan or a person who has been designated on the OAAS Authorized Representative Form as such.

In reference to G.a.i.d.1, during the record review process, OAAS Regional Office staff review monthly support coordination documentation to ensure that each participant was provided appropriate and sufficient coordination and support to access health care services identified in the service plan.

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The State's method for addressing individual problems identified through the performance measure G.a.i.a.1 and G.a.i.b.1 are as follows:

The OAAS regional managers are responsible for remediation of all critical incidents and investigations that were not completed within required time frames or according to policy.

In reference to G.a.i.a.1, if any critical incidents lacked evidence of effective resolution and inclusion of preventative measures as recommended by APS, the Regional Manager will be notified, technical assistance provided, and instructions will be given to correct each occurrence.

In reference to G.a.i.b.2, regional managers receive quarterly incident closure reports generated from the critical incident database. Any incident investigation not completed within the required time frame will be completed no later than the end of the quarter following that in which it was due. Concerning timely incident closure, the regional managers will analyze the report for their regions quarterly and work with regional office staff, direct service providers (DSPs), and support coordination agencies to remediate current deficiencies and improve future performance. The regional managers also have the responsibility to notify the regional program operations manager and/or division director of non-compliance trends identified within their region including problems with providers who are non-responsive to technical assistance and guidance. Any systemic remediation needs identified are presented to the OAAS Quality Review Team for resolution.

The State's method for addressing individual problems identified through the performance measures G.a.i.b.2, G.a.i.c.1, and G.a.i.d.1 are as follows:

Regional Office staff perform monitoring of Support Coordinator Agencies (SCA) at least annually utilizing the OAAS Support Coordination Monitoring Tools:

- Participant Interview;

- Participant Record Review;
- Support Coordinator Interview; and
- Agency Review.

The processes for scoring and determining the necessity for corrective actions are located in the Support Coordination Agency Monitoring Policy and Procedures Manual. After all elements are assessed and scored, the Regional Office reviewer documents the findings, including the Statement of Determination which delineates every remediation required with the service plan and required responses/plans of correction expected from the SCA. Based on the scope and severity of findings, the SCA is assigned a Statement of Determination at Level I, Level II, or Level III. The Regional Office and/or State Office follow-up according to timelines associated with each level to ensure that plans of correction are implemented and effective. If a Plan of Correction, Progress Report and/or Follow-up Report remains unapproved by the time of the next annual review the agency placed on the next level with more stringent requirements. With a finding of satisfactory or a recommendation for improvement no remediation is required. These remediation activities will be documented through tracking events in the Support Coordination Monitoring database.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 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 (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, 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 QIS 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 QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

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 Department of Health (LDH)utilizes a collaborative approach to develop and maintain its Quality Improvement Strategy (QIS). Louisiana's Medicaid agency, the Bureau of Health Services Financing, Medicaid Program Support and Waivers (BHSF/MPSW) Section, oversees the implementation of home and community-based services (HCBS) waivers. The Office of Aging and Adult Services (OAAS) is the operating agency for the Community Choices Waiver. All Support coordination agencies are certified and sign a performance agreement with OAAS. Through this agreement, OAAS oversees and monitors each agency's performance as it relates to performing level of care assessments, developing and approving service plans, and ensuring the health and welfare of waiver participants. All of the above mentioned entities also work collaboratively with Adult Protective Services, LDH's Health Standards Section (HSS), and/or law enforcement agencies as deemed necessary. The process of trending, prioritizing and implementing system improvement activities are required on all levels with upward reporting to the operating agency for oversight and management of the Quality Improvement Strategy including a summary of root cause analysis completed at each level and recommendations for design changes or other system improvements. This approach provides opportunities for continued communication and review of performance measures, discovery data, and remediation activities.

The Quality Improvement Strategy (QIS) for the Community Choices Waiver is part of a cross-waiver function of OAAS and the Office for Citizens with Developmental Disabilities (OCDD). Additionally, beginning in 2014 with the renewal of the Community Choices Waiver (LA.0866.R01.00), OAAS began utilizing composite sampling and consolidated evidence reporting across its two aging and adult disability waivers in accordance with CMS' quality memo "Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers" released in 2014. These changes served to streamline monitoring, remediation, and reporting for both waivers and resulted in increased efficiency to discovery methods and implementing systemic improvements.

The purpose of the QIS is to assess and promote the quality of waiver programs serving elders and adults with physical, intellectual and developmental disabilities. The QIS assures a consistent and high standard of quality across LDH's waiver programs through:

- Adoption of common standards and performance measures against which waiver programs are evaluated.
- Development of policies, tools, practices, training, protocols, contracts and agreements that embody sound approaches to managing, delivering and assessing home and community-based services and supports. To the extent possible, HCBS waiver policies and practices have shared purposes, language, and expectations.
- Streamlining and consolidating functions to strengthen the collection and analysis of timely and reliable data on waiver performance.
- A transparent system of reporting performance data for use by program managers, policymakers, consumers, providers, and other stakeholders.
- A structured and coordinated process to identify improvement opportunities, set priorities, allocate resources, and implement effective strategies.
- A coordinated approach for evaluating the effectiveness of the QIS in meeting program goals.

LDH has a multi-tiered system for quality improvement. Each level (Direct Service Providers, Support Coordination Agencies, OAAS, and BHSF) is required to design and implement a Quality Management Strategy which is further described below.

Direct Service Provider and Support Coordination Agency Processes:

Direct Service Provider and Support Coordination Agencies are required to have a Quality Management Strategy that includes collecting information and data to learn about the quality of services, analyzing and reviewing data to identify trends and patterns, prioritizing improvement goals, implementing the strategies and actions on their quality enhancement plan, and evaluating the effectiveness of the strategies. At a minimum, providers and SC agencies must review: 1) critical incident data, 2) complaint/grievance data, and 3) interview/survey data from participants and families. The review process must include review by internal review team(s) composed of agency programmatic and management staff.

OAAS Processes:

Aggregate data for waiver performance indicators are analyzed on a quarterly basis by OAAS Quality and Program Operations staff. The review of this data allows OAAS to routinely assess the performance of support

coordination agencies, require remediation/corrective action plans (when appropriate), and to monitor the status of remediation activities. In addition to the aggregate state-level analysis, performance measure data is also analyzed across the nine service regions of the state and for each support coordination agency. This targeted analysis allows OAAS to determine whether any substandard performance is occurring on a systemic, statewide level or is localized to a particular region or agency(ies) and facilitates remediation efforts. Upon completion of the analysis, a summary report is presented to the OAAS Quality Review Committee (QRC). The QRC's membership includes OAAS Executive Management staff and managers from OAAS' Policy, Program Operations, and Research and Quality Management divisions. The QRC reviews the report and, in response to needs identified in the analysis, makes recommendations for changes in policies, procedures, and the QIS as needed. When significant changes are proposed to the QIS, OAAS allows stakeholders to review and provide input. Recommendations, performance indicator data reports, and quality improvement initiatives status reports are submitted to BHSF/MPSW on a quarterly basis.

BHSF/MPSW Processes:

Medicaid/Program Offices Quarterly Meeting – This group convenes at least quarterly to perform executive level oversight of the performance of HCBS waivers, assure their effectiveness and efficiency, and discuss any other programmatic issues common to the program offices and Medicaid. Goals are to act upon issues and recommendations received from the Medicaid HCBS Oversight Committee and other HCBS workgroups. This meeting is a forum for executive level problem resolution, planning, and development of quality redesign strategies. Members include representatives from MPSW, the Medicaid Director or Deputy Director, the OAAS Assistant Secretary or Deputy Assistant Secretary, and other designated staff.

Medicaid HCBS Oversight Committee – meets at least quarterly with the specific purpose to ensure proper oversight of LDH's HCBS waiver programs. Goals are to review current performance reports, determine need for new activities concerning quality and oversight in waiver programs, and ensure adequate remediation enforcement. Quality recommendations or issues which cannot be resolved at this level are placed on the agenda of the Medicaid/Program Offices Quarterly Meeting. Oversight members include HCBS quality management staff from MPSW and OAAS and are chaired by the MPSW Section Chief or designee. The committee meets at least quarterly with the following standing agenda items:

- OAAS operating agency staff present their analysis of all performance measure findings, remediation activities, and systemic improvements to MPSW as defined in the 1915(c) waiver QIS
- MPSW Section Chief or designee indicates approval or disapproval of quarterly/annual data and activities;
- Based on evidence presented, MPSW staff provides technical assistance, guidance, and support to the operating agency staff;
- MPSW performs administrative oversight functions for OAAS HCBS programs.
- MPSW/OAAS/Medicaid Data Contractor Meetings – facilitates monthly meetings with OAAS and the Medicaid data contractor to discuss waiver issues, problems, and situations which have arisen that do not align with program policy. At these meetings, solutions are formulated, corrective actions are agreed upon, and follow-up implemented by OAAS as necessary in the form of internal policy or provider policy.

Ad Hoc Cross-Population HCBS Oversight Meetings – Additional meetings will be held jointly between MPSW, OAAS, and OCDD on an as needed basis for the following purposes:
- Collaborate on design and implementation of a comprehensive system of cross-population continuous quality improvement
- Present Quality Improvement Projects (QIP)
- Share ongoing communication of what works, doesn't work, and best practices.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: Medicaid HCBS Oversight Committe	☐ **Other** Specify:

b. System Design Changes

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

OAAS Process:

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

BHSF/MPSW Processes:

Medicaid HCBS Oversight Committee – meets at least quarterly with the specific purpose to ensure proper oversight of the OAAS and OCDD operated HCBS waiver programs. Goals are to review current performance reports, determine need for new activities concerning quality and oversight in waiver programs, and ensure adequate monitoring of remediation activities. Quality recommendations or issues which cannot be resolved at this level are placed on the agenda of the Medicaid/Program Offices Quarterly Meeting. Oversight members include HCBS quality management staff from MPSW and OAAS and the committee is chaired by the MPSW Section Chief or designee. The committee meets at least quarterly with the following standing agenda items:
-OAAS staff present their analysis of all performance measure findings, remediation activities, and systemic improvements to MPSW as defined in the 1915(c) waiver QIS
-MPSW Section Chief or designee indicates approval or disapproval of quarterly/annual data and activities;
-Based on evidence presented, MPSW staff provides technical assistance, guidance, and support to the operating agency staff;
-MPSW performs administrative oversight functions for OAAS HCBS waiver programs.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The BHSF/MPSW Section works in collaboration with the operating agency, OAAS, to periodically review the QIS. Meetings are held to review and evaluate performance indicators, discovery methods, remediation strategies, systemic issues, policies, procedures and other issues that surface as a result of monitoring activities. Technical assistance is provided to the operating agency as needed by the BHSF/MPSW Section.

OAAS' Quality Review Committee meets at least quarterly and provides ongoing oversight and management of the QIS.
OAAS routinely conducts Participant Experience Surveys to gain first-hand information on participants' experience with and satisfaction of their HCBS. OAAS aggregates findings to identify areas of concern in service delivery in order to improve policies, procedures, and the QIS. New priority projects may be identified to better align the QIS to the needs of OAAS staff, support coordinators and providers and, most importantly, to improve desired outcomes for HCBS waiver participants.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ◉ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

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).*

To ensure compliance among Medicaid providers and prevent fraud and misuse in HCBS waiver programs, stringent measures are in place. The Single Audit Act obligates Medicaid providers to meet specific standards, with the Louisiana Legislative Auditor conducting periodic audits to maintain enrollment. Providers receiving certain funds must submit independent audits annually to retain Medicaid eligibility. Failure to do so can lead to disenrollment. Additionally, the Program Integrity's Surveillance and Utilization Review (SURS) Unit, part of the Louisiana Department of Health (LDH), conducts post-payment reviews of fee-for-service Medicaid providers, as per the Louisiana Surveillance and Utilization Review Subsystem (SURS) Rule and the Medical Assistance Program Integrity Law (MAPIL). This ensures proper use of Medicaid funds and eligible individuals receive healthcare.

The SURS Unit has four primary functions: Data Analytics, Prepayment Reviews, Special Investigations, and Auditing Services. Data Analytics involves skilled staff ensuring compliance with regulations, while Prepayment Reviews use coding checks to verify payments. Auditing Services conducts comprehensive audits and addresses fraud, waste, and abuse. Alerts, such as Provider Federal Exclusion Match and Beneficiary Duplicate Services, assist in detecting potential violations. The Provider Profile provides insights into waiver providers. An array of alerts is utilized, each serving a specific purpose, such as identifying provider billing patterns.

Preliminary investigations by LDH's Special Investigations team examine flagged cases for billing anomalies. SURS conducts preliminary investigations when complaints or questionable practices are identified. Law enforcement referrals and program assessments are also part of the process. Full investigations follow detailed audits, involving record acquisition, and aim to identify issues like overpayments, fraud, and medical necessity concerns. SURS is compliant with regulations, such as referring cases of suspected provider fraud to Medicaid fraud control units and verifying services with recipients. Providers can self-report policy violations to mitigate risk exposure.

The Data Analytics unit is comprised of highly technically skilled staff knowledgeable in systems, reporting, data warehousing, programming, statistical research, etc. as well as, acute, primary, and behavioral healthcare regulations. With these skill sets, the data analytics team is primarily responsible for all analytic/technical functions of Program Integrity and assisting, where appropriate, other sections within Medicaid. This unit insures that the state complies with 42 CFR §456.3, the System Admin will support the current SURS system to insure compliance. This regulation requires that the Medicaid agency implement a statewide surveillance and utilization control program safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments, assesses the quality of those services, provides for the control of the utilization of all services provided under the plan in accordance with subpart B of this part; and provides for the control of the utilization of inpatient services in accordance with subparts C through I of this part.

The pre-payment review process in Medicaid claims aims to ensure the correct payment of Medicaid services before funds are released. The utilization of National Correct Coding Initiative (NCCI) edits and claim checks is central to this procedure. The National Correct Coding Initiative (NCCI) edits were instituted by the Centers for Medicare & Medicaid Services (CMS) to standardize coding practices and curb incorrect coding that could result in inappropriate payments. Central to this system are the Procedure-to-Procedure (PTP) Edits, which identify services that shouldn't be billed concurrently for the same beneficiary due to their inherent overlap or clinical improbability. Another key component is the Medically Unlikely Edits (MUEs), which set limits on the number of times a specific service can be billed for one beneficiary in a single day, reflecting its medical implausibility under regular circumstances.
Complementing NCCI edits in the Medicaid pre-payment review process are claim checks. These automated checks ensure that the services billed align with the diagnosis given, are covered by Medicaid, and aren't duplicate bills for the same beneficiary by the same or different providers. Furthermore, these checks authenticate both the provider's authority to bill Medicaid and the beneficiary's eligibility for Medicaid on the service date.

To bolster program integrity, the primary functions of Audit Services are carried out by experienced clinical staff, with the overarching objective being to shield Medicaid from fraud, waste, and abuse. Their responsibilities span a gamut of activities, including executing comprehensive audits, engaging in informal hearings and appeals, pinpointing and reclaiming overpayments, and educating providers.
A key facet of their work revolves around comprehensive audits of Medicaid providers. Such audits demand a profound understanding of Medicaid's diverse program policies, rules, and regulations. When preliminary examinations spotlight patterns of incorrect billing, full audits, as mandated by sections 42 CFR 455.15(c) and 42 CFR 455.16, are initiated. These meticulous reviews often involve procuring records, whether via mail or direct onsite visits.

Upon completion of full reviews, potential issues such as overpayments, questions of medical necessity, suspected fraud, and system discrepancies are assessed. If improprieties are identified, several courses of action can be pursued as prescribed by 42 CFR 455.16 and La. R.S. 46:437.1. Actions might include issuing warning letters, suspending or terminating provider participation in Medicaid, reclaiming incorrect payments, or even implementing additional state-

specific sanctions. The objective is to ensure that every case is thoroughly investigated and resolved, upholding the integrity and fiscal responsibility of the Medicaid program.

In contrast to claim-processing subsystems that handle claims on an individual basis, the Surveillance Utilization Review Subsystem (SURS) distinguishes itself by its ability to analyze post-payment data for multiple claims simultaneously, facilitating the identification of suspicious provider billing patterns. This capability aligns with federal regulations mandating states to establish a post-payment review process empowering state personnel to construct and assess provider service profiles, including exception criteria.
The State Utilization Review Subsystem (SURS) utilized by LDH (called Fraud Detect) employs provider profiles as essential resources. These profiles seamlessly integrate Medicaid data with third-party information to provide deep insights into waiver providers. They supply crucial demographic and customer data related to specific entities, facilitating the timely identification of potential signs of fraud or abuse linked to these entities. The Provider Profile encompasses a comprehensive array of information, including:

1. *Provider Demographics*
2. *Fraud, Waste, and Abuse (FWA) Indicators*
3. *Enrollment and Address Summaries*
4. *Provider Risk Score*
5. *Claims Summary*
6. *Claims Detail Report*
7. *Claims Visualizer*
8. *Provider Groups Information*
9. *Provider Profile Map*
10. *Alert Information*
11. *Complaints and Tips Data*
12. *Historical Audit Records*

The multifaceted Provider Profile equips LDH with a comprehensive perspective on provider activities, enhancing their ability to identify and address potential risks and anomalies within the healthcare billing ecosystem. To bolster healthcare fraud detection and prevention, an extensive array of alerts has been meticulously developed. These alerts harness the power of machine learning algorithms, leveraging peer comparisons, statistical analysis, and outlier detection to serve as potent instruments in safeguarding against fraud, waste, and abuse within the healthcare system.

Here is a concise compilation of these vital alerts:
1. Provider Federal Exclusion Match: This alert identifies providers listed on federal exclusion databases (LEIE or GSA SAM), with severity ranked by the total paid dollars associated with post-exclusion claims.
2. Beneficiary Duplicate Services: It detects beneficiaries with duplicate claims for specific services on the same date but with different billing providers, ranking them based on total paid dollars.
3. Provider Providers with High Volume of Traveling Beneficiaries (Treatment Based): This alert flags providers with a significant percentage of beneficiaries traveling for treatment, with ranking determined by the paid amount for traveling beneficiaries.
4. Provider Peer Comparison - Claims/Encounters Per Beneficiary: It highlights providers with an unusually high number of claims or encounters per beneficiary compared to their peers. The top 1% providers with higher risk and above-average claims are identified.
5. Provider Providers with Spikes in Billing Activity: This alert identifies providers with substantial spikes in billed amounts relative to their historical billing, ranking them based on the magnitude of these spikes.
6. Provider Overlapping Outpatient Services with Inpatient Stay: It identifies providers with claims for outpatient services during inpatient hospital care (excluding admission/discharge dates), with ranking based on the total paid dollars for overlapping claims.
7. Provider Physician Services Time Outlier: This alert flags providers with an abnormal number of service dates with extended services, ranking them based on the total paid amount for excessive days.
8. Provider Procedure-to-Procedure Conflicts: It identifies providers billing for conflicting HCPCS codes that should not typically be reported together, ranking them based on the total paid dollars associated with claims/encounters in conflict.
9. Beneficiary with High-Risk Drugs from Multiple Prescribers and/or Pharmacies: This alert identifies beneficiaries with multiple opioid prescriptions from multiple prescribers and pharmacies, ranking them based on the quantities dispensed for opioid prescriptions.
10. Provider Prescriber with Spikes in Prescribing Activity: It detects prescribers with significant spikes in prescribing activity compared to historical data, with ranking indicating the extent of the spike.
11. Beneficiary Potential Prescription Drug Diversion: This alert identifies beneficiaries with opioid prescriptions but without evaluation & management (E&M) services within 12 months, ranking them based on the total paid dollars

associated with high-risk prescriptions.
12. Provider Peer Comparison - Paid Amount Per Beneficiary: It highlights providers with a high average paid amount per beneficiary compared to peers, flagging the top 1% providers with higher risk and above-average paid amounts.
13. HCPCS/NDC Conflict- Identifies providers billing for conflicting HCPCS Code and NDC combinations.
14. Beneficiary Procedure/Age Conflict- identifies beneficiaries with claims or encounters for services that appear inappropriate for the beneficiary's age.
15. Providers with Excessive Hours per Day- Identifies billing providers with servicing providers who are outliers based on number of service dates with at least 10 hours of services provided.
16. Provider Outlier for Sunday Claims- Identifies the top 100 billing providers based on number of claims filed for a date of service which falls on a Sunday.

CONTINUE IN OPTIONAL

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

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

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

Performance Measure:
I.a.i.a.1 # and % of waiver claims coded & paid for in accordance with the reimbursement methodology specified in the approved waiver application and only for those services rendered. Numerator=# of waiver claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver application and only for those services rendered; Denominator=Total # of claims paid.

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
I.a.i.b.1. Number and percentage of rate changes that are approved by MPSW and consistent with the CMS approved rate methodology. Numerator= Number of rate changes approved by MSPW and consistent with the CMS approved rate methodology; Denominator= Total number of rate changes

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

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

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

Data Aggregation and Analysis:

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

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

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.*

I.a.i.a.1.

BHSF determines all waiver payment amounts/rates in collaboration with OAAS, Division of Health Economics, and as necessary the Rate & Audit section. At the time of each requested rate change, MPSW and the Rate and Audit section reviews evidence that the rate adjustment was applied according to the methodology described in the waiver document. When a rate adjustment proposal is submitted without documentation which supports the current methodology it will not be approved and MPSW will offer technical guidance.

I.a.i.b.1

Upon annual review and analysis of all waiver claims payments through Medicaid Data Warehouse report generation, any discrepancies are resolved individually and systemically in collaboration with Medicaid Information Management Systems staff who oversee the Fiscal Intermediary.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- (●) ***No***
- ( ) ***Yes***

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

Appendix I: Financial Accountability

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

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

Rates for this waiver are determined by OAAS with input from a group of interested parties, including but not limited to providers, participants, advocates, and Medicaid representatives. Proposed service rates are promulgated through the Medicaid rulemaking process and includes an opportunity for public comment. Final approval of proposed rates and oversight of the rate determination process is done by the Medicaid Director or designee. New rates are published on the state's Medicaid Website, available at SCAs and through request.

1.OAAS recommends rates to Medicaid based on the following hierarchy of factors: a)If there is a comparable service already existing in another OAAS waiver program that rate is mirrored b)If there is no existing comparable service, OAAS explores the rates that are compatible with other similar services which are provided by Medicaid in other waivers or in the state plan & c)If no comparable Medicaid services and rates exist, OAAS explores services in the general community that are comparable and attempts to match the prevailing competitive rates.

2.Based on the choices available in #1, OAAS recommends the service rate to Medicaid to be reviewed and a determination made of the fiscal impact and budget availability for funding with a final determination on the service rate. No rate can be implemented without the approval of the Medicaid Agency(BHSF). Rates for each service are based on the following:

SUPPORT COORDINATION(SC) and TRANSITION INTENSIVE SUPPORT COORDINATION(TISC): SC rate was established pursuant to the Barthelemy Settlement which was an Olmstead based lawsuit against the state of LA. SC rates for this waiver are $140 per mth for regular SC yrs 1-2; $155 yr 3; $202 yrs 4-5 and $157 per month for TISC yrs 1-2; $172 yr 3; & $224 yrs 4-5. For yrs 1-2: Other intrastate HCBS waivers average $142.40 per mth. LA has 3 other waivers offering SC services with reimbursement on a mthly basis ranging in reimbursement from $125 to $155 per mth. OAAS hasn't seen any loss of SCAs and the provider network is adequate to meet participant needs. Initial Plan of Care Development one-time payment amount was determined by taking the average rate for waiver support coordination and multiplying it by the estimated time (about 2.5 months) that the SC spends working with waiver participants to conduct the LOC assessment and complete the POC.

PERSONAL ASSISTANCE SERVICES(PAS): The current rate was developed from a blending of the Personal Care Services(PCS) and Companion Care rates established in the Elderly and Disabled Adult(EDA)Waiver(predecessor to CCW). As stated in EDA Waiver, rates for PCS and Companion/Shared Companion Care Services "were based upon the ability of DSPs to recruit and retain qualified staff which depends on the adequacy of reimbursement rates, both in general and in relation to those paid to other providers competing in same labor market. Rates for Shared Companion Services were based on rates set for other shared services provided via other waiver and state plan programs." The State Medicaid agency implemented mandatory cost reporting for HCBS providers who provide PCS and developed a cost-based reimbursement methodology in 2016 as outlined in LAC50.XXI.703. The cost reports were used to verify expenditures and to support rate setting for PCS rendered to participants. The info from the reports were used to determine the base PCA wage, employee benefits factor, productivity adjustment, admin costs, program support costs, and staffing ratios. The Department requested funding to implement this reimbursement methodology but was unsuccessful in obtaining that funding. The Dept also continues to assess its PCA provider network and ensures that an adequate # of providers are enrolled in all regions of LA. Cost reports are submitted annually. The State will use a rate validation process involving comparison of current provider reimbursement rates to reimbursement rates established using the dept's reimbursement methodology. The department will be solely responsible for determining the sufficiency of the current reimbursement rates during the rate validation process. Any reimbursement rate change deemed necessary due to rate validation process will be subject to legislative budgetary appropriation restrictions prior to implementation. An examination of state specific data for DSWs available from the LA Workforce Commission is used as a means to identify a base employee wage for DSWs. Rates are required to be reviewed bi-annually using Cost Report Data. Newly suggested rates based on wage rate adjustments are subject to the availability of funding or LDH secured appropriation. When PAS is self-directed(SD), the method of rate determination differs from when the service is provider managed. Rates for SD PAS is negotiated by the participant and DSW and submitted for approval. SD PAS does not have a pay range; but employers must pay their employees at least the Federal min wage and the FEA ensures that employees are paid at least the Federal min wage. The SD employer has full discretion in hiring process for recruiting, hiring and determining rate of pay. SC monitors the participant's budget to ensure that pay rates are appropriate to fund all needed waiver services identified in the POC. The SC is responsible for ensuring that all services in the POC are funded and delivered. If the SC identifies that the chosen pay rate will not allow for this, they notify OAAS Regional Office(RO) and/or State Office(SO) for assistance. OAAS RO/SO will contact the employer to review services on the participant's POC and which of these identified services are necessary to maintain health and safety. If OAAS determines that the pay rate is restricting or prohibiting any of these necessary services, then it will require the employer to modify the pay rate or discontinue participation in the SD program. The SCs conduct at least monthly monitoring calls/visits to ensure that services were delivered in accordance with the POC.

ENVIRONMENTAL ACCESSIBILITIES ADAPTATIONS and ASSISTIVE DEVICES AND MEDICAL SUPPLIES: Paid at the cost of the provision of services and is subject to availability in the participant's budget.

TRANSITION SERVICES: This one-time fee is based upon the total amount of funding available divided by the one-time fee of $1,500 to determine the number of transitional participants to serve. This cap was set based on historical cost allowed for providing the service in other waivers. Transition Services are not factored into the budget.
ADULT DAY HEALTH CARE(ADHC): Methodology for calculating each individual component of the overall ADHC rate is a product of the median cost multiplied by an index factor as approved by legislation detailed in LAC50.XXI.2915. The resultant calculations provide reasonable and adequate reimbursement required to cover the costs of economic and efficient ADHC services. The base rate is calculated using the most recent audit or desk review cost for all ADHC providers filing acceptable full year cost reports and includes the following components: Direct care; Care related costs; Administrative and operating costs; Property/capital costs; and Transportation costs. Because of the wide variation in transportation cost, which is influenced by the rural or urban location of the ADHC center and the number of participants using the ADHC's transportation services versus other means of transportation(provided by family, etc), the transportation component of ADHC reimbursement is calculated and paid individually to each ADHC center. LDH has a contract with a CPA firm to perform a full scope site audit on up to 32 facilities' cost reports each year. The CPA firm uses Agreed Upon Procedures that have been approved each yr by LDH to perform the audits. The firm makes adjustments for any costs that it finds that are unallowable. The firm then incorporates these adjustments into the annual cost report database that it prepares for LDH.
SKILLED MAINTENANCE THERAPY and NURSING: Rates were established by looking at the rate of similar services provided under the Medicaid State Plan. For state plan look-a-like services, the rate of the similar service under the state plan was used(RN, LPN, CNA). For all other professional services, the rate was negotiated based upon the provider cost of rendering the service balanced against the potential cost of waiver and the availability of state funding. The negotiation process involved meeting with providers of the services, collection of informal surveys, and information gathered from the LA Workforce Commission(State Dept of Labor). After all data was gathered, a rate was developed and proposed. This suggested rate was then adjusted after consideration of available funding or LDH's ability to secure appropriation.
HOME DELIVERED MEALS(HDMs): HDM rates were based on rates paid to providers contracted by the State Unit on Aging to furnish meals through TitleIIIb. of the Older Americans Act. Rates for Medically Tailored Meals(MTMs) and Nutritional Counseling were established by looking at rates for the same/similar services provided in other State's Medicaid waivers or managed care programs and with input from existing CCW HDM providers qualified to offer MTMs and nutritional counseling. MTMs and Nutritional counseling are not factored into the budget.
CAREGIVER TEMPORARY SUPPORT SERVICES(RESPITE): Rates were based on existing Medicaid fee-for-service rates for all provider types except for services provided in a Respite Center. Respite center rates were negotiated based upon the estimated provider cost of rendering the service and similar services as provided in other waivers. Caregiver Temporary Support Services(Respite) rates may be delivered in the home, in a day center or overnight at a facility(e.g. nursing facility, etc.). Rates for respite in each of these service settings were based on the rate for the associated waiver service (ADHC, etc.) or a comparable facility overnight rate. The State used the previous EDA Waiver to set the in-home and center-based respite rates using the PAS and ADHC service rates. For the nursing facility/respite care center and Assisted Living respite rates, the State used comparable facility rates to determine each nightly rate.
HOUSING STABILIZATION and HOUSING TRANSITION OR CRISIS INTERVENTION: Rates are based upon the rate paid to SCAs that employ individuals who have obtained a bachelor's degree and are qualified to provide 2 levels of supervision. A SCA trainer or nurse consultant who meets the requirements as a SC can also be reimbursed a per quarter hr rate for services provided. Admin support, travel and office operating expenses are included in the 15 min rate.
MONITORED IN-HOME CAREGIVING: The 2 distinct Levels of MIHC reimbursement were based on NH per diem rates. Level 1 was 40% of the average NH per diem rate(after subtracting the provider tax) & Level 2 was 60% of the average NH per diem rate(after subtracting the provider tax).
ASSISTIVE TECHNOLOGY(AT): Paid at the cost of the provision of services, not to exceed $250 per unit of service and $50 for the procurement. This cap was based on market research of commercially available AT devices that can be used to increase, maintain or improve functional capabilities. AT is not factored in the budget.
FINANCIAL MGMT SERVICES(FMS): The Medicaid agency determines the rate for FMS. The state uses the Fee Schedule model of rate setting for this service. The initial rate was determined in Nov 2022 using rates included in contracts executed as a result of LA's last RFP process in 2019. Rates for the 2 contractors were averaged to calculate the base rate for this service. An add-on to this rate was calculated to cover the cost of criminal background checks using six months of historical costs for BGC's invoiced by the contractors.

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

Billings for waiver services provided to participants in the waiver program are submitted first to the Medicaid data contractor for prior authorization. After services are authorized, providers bill directly to the Medicaid fiscal intermediary for payment. The State does not offer an option for providers to bill Medicaid directly.

Providers bill the Medicaid fiscal intermediary directly. All Fee for Service payments that are outside of managed care in Louisiana, including HCBS, are billed directly to the Medicaid fiscal intermediary. However, HCBS claims are not approved for payment unless Post Authorization is received from the data contractor.

Appendix I: Financial Accountability

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

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

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

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

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

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

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

Appendix I: Financial Accountability

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

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

Eligibility of payments for individuals is verified by the prior and post authorization process performed by the Medicaid data contractor. Prior to authorizing services for payment, the contractor confirms that the participant is eligible for Medicaid waiver services. Once this is confirmed, the services are authorized in the following ways:

1. The services as prescribed in the approved Plan of Care (POC) are entered into the prior authorization system.

2. Upon the provision of services to the participant, the provider submits the service utilization data for post authorization to verify that services were delivered in the scope, duration, and frequency as specified in the approved POC.

3. The post authorization entity checks the service utilization record against the participant's approved POC which identifies the prior authorized services.

4. Services provided to participants that are not listed on the prior authorization system are rejected and ineligible for payment until all discrepancies are resolved.

5. The provider then submits claims for approved services to the fiscal intermediary for adjudication and payment.

When an overpayment is identified, SURS sends a memo to LDH Fiscal to setup a negative balance on the provider's online file to capture payments thru remittance advices or on offline where the provider would mail in checks via the postal service. SURS provides LDH Fiscal the recoupment amount, provider name & number and the dates of review. SURS also send a copy of the provider recoupment letter for backup documentation. LDH Fiscal completes the necessary paperwork (CMS-64) to return the federal share within the required timeframes per CMS.

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

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

- ( ) ***Payments for waiver services are not made through an approved MMIS.***

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

- ( ) ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a***

monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

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

Payments are not billed directly to LDH Medicaid but go through the fiscal intermediary. The Medicaid Data Management Contractor prior authorizes services which release the services for payment to the fiscal intermediary. Once prior authorized, the provider bills the fiscal intermediary for payment, either electronically or using a paper claim.

The Medicaid enrolled fiscal employer agent will provide fiscal management services to self-direction participants. Payment will be made to employees for direct services to the waiver self-direction participants related to the service, Personal Assistance Services (PAS). The fiscal employer agent will process the participant's employer related payroll, withholding, and deposit the required employment related taxes. The operating agency and Medicaid will jointly oversee the fiscal agent by monitoring compliance with the performance agreement, provider manual, and Medicaid provider agreement.

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

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

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

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:

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

○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ○ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ◉ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

Louisiana recognizes an Organized Health Care Delivery System (OHCDS) as an entity with an identifiable component within its mission to provide services to individuals receiving Community Choices Waiver services. The entity must be a qualified Medicaid provider and render at least one of the following services: PAS, Home delivered meals, skilled maintenance therapy, nursing, care giver temporary support services, assistive devices and medical supplies, environmental accessibility adaptations, or ADHC. So long as the entity continues to furnish at least one service itself, it may contract with other qualified providers to furnish waiver services. Contracting with ADHC is required only if there is an ADHC provider in the service area.

Entities that function as an OHCDS must ensure that subcontracted entities meet all applicable provider qualification standards for the services they are rendering.
a) Qualified Community Choices Waiver providers may apply to become an OHCDS as part of the initial enrollment process or by amending their enrollment must meet all regulatory requirements applicable to an OHCDS.
b) Providers are in no way required to contract with an OHCDS to provide waiver services. Provision of services through an OHCDS is strictly voluntary and any qualified provider may enroll independently in Medicaid.
c) Participant's have the right to be able to choose freely among qualified providers at any time. Please see Appendix D-1-F for how this assurance is met. The freedom of choice list includes providers that function as both an OHCDS as well as those that do not. The participant is free to choose among willing and qualified providers, despite their organization as an OHCDS.
d) The OHCDS must attest that all provider qualifications are met in accordance with all applicable waiver provider qualifications as set forth in the waiver document.
e) OAAS will review OHCDS contracts with providers to ensure that they meet applicable waiver requirements for the service they are providing
f) The cost of the vendor good or service must be equal to the rate on file for the same service provided.

Edits in place with the fiscal intermediary ensure that a single State approved rate will be paid to the OHCDS provider for each service they are authorized to provide.

Waiver participants may not be required to secure services exclusively through an OHCDS.

iii. Contracts with MCOs, PIHPs or PAHPs.

- (◉) ***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 section 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 section 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 section 1915(b)/section 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 section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent section 1115/section 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 section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please***

select this option.

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver 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 section 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.

Appendix I: Financial Accountability

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

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

☒ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

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

☐ ***Other State Level Source(s) of Funds.***

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

Appendix I: Financial Accountability

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

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

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

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

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

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

Appendix I: Financial Accountability

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

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

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

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

Check each that applies:

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

☐ ***Provider-related donations***

☐ ***Federal funds***

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

Appendix I: Financial Accountability

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

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

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

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

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

Do not complete this item.

Appendix I: Financial Accountability

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

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

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

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

Appendix I: Financial Accountability

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

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

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

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

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

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

Specify:

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

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

Appendix I: Financial Accountability

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

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

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

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

Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	32720.74	6246.00	38966.74	47670.00	5309.00	52979.00	14012.26
2	29686.17	9599.99	39286.16	55248.97	6994.67	62243.64	22957.48
3	29688.04	9871.67	39559.71	57856.72	7242.85	65099.57	25539.86
4	29689.92	10151.04	39840.96	60587.56	7499.84	68087.40	28246.44
5	29691.84	10438.31	40130.15	63447.29	7765.94	71213.23	31083.08

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	7908	7908
Year 2	9381	9381
Year 3	9381	9381
Year 4	9381	9381
Year 5	9381	9381

Appendix J: Cost Neutrality Demonstration

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

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

The average length of stay is calculated as the total number of days of waiver eligibility of all Community Choices Waiver participants divided by the number of unduplicated participants over the waiver year.

Estimates for future year's average length of stay were calculated by taking the average length of stay from the FY17 – FY21 Community Choices Waiver HCFA 372 reports. An average was used because there was no clear trend; LOS ranged between 310.6 and 315.2 during the lookback period.

The calculated ALOS from FY17-21 372 reports is 313.3:

(315.7 + 313.8 + 314.1 +310.6 +312.5)/5 = 313.3

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 and methodology for these estimates is as follows:*

Factor D estimates are computed by multiplying the number of users for each service times the average units per user times the average cost per unit for each service available in the waiver. Each service cost is then summed and divided by the total unduplicated count of individuals served in the waiver year.

Individual waiver service users are calculated by taking the recipient number for each service divided by the total unduplicated waiver participants from the FY21 372 report to calculate a percentage of recipients that use the service. The percentage is then applied to the estimated total unduplicated participants (item J-2a).

Unduplicated number of participants (B-3.a) was calculated as the unduplicated number of recipients reported for year 5 (FY24) of the approved waiver plus additional slots the state plans to fill in future years.

Estimates for average number of units and average cost per unit for each service were based on an analysis of FY17 - FY21 HCFA 372 reports and claims analysis of service utilization.

Due to the Public Health Emergency, utilization was not consistent across the time period for all services. For example, ADHC as it is a center based service and was closed for part of the pandemic. Number of recipients and utilization for this service decreased, from 51 recipients to only 6 and per person average cost of $73.22 to $3.52. Therefore, FY19 (waiver year 2) was used for the following waiver service estimates; ADHC, Environmental Accessibility Adaptations (EAA), Transition Services and Transition Intensive Support Coordination.

Increasing trends in average cost for EAA were identified between FY17 and FY21. This trend is assumed to continue due to inflation in construction costs. Therefore, the inflation index for the first half of calendar year 2023 (1.5%) was factored into the estimates for future years.

For services with little to no historical utilization, waiver year 5 of the currently approved waiver were used. This includes Therapies, Nursing and Assistive Devices - Telecare.

The methodology for calculating estimated costs for Financial Management Services includes 1) the projected number of users were calculated based on the current number of participants electing to self-direct their services and projections were trended for future years based on historical enrollment data; 2) the average units per user were calculated by multiplying the number of months in a year (based on the monthly unit type) by the average length of stay for the waiver; and 3) the average cost/unit is the rate established for this service.

The number of users for Assistive Technology was based on a poll conducted by OAAS regional office and CCW support coordinators to estimate the number of participants that would benefit from the service. Number of units is capped at 1 per user. Unit cost was set based on market research of commercially available assistive technology. The number of users for Assistive Technology – Procurement is set equal to the number of users for Assistive Technology. Number of units is capped at 1 per user. Unit cost is set at the fee for this service ($50).

The number of users for Medically Tailored Meals, Nutritional Counseling, and Medically Tailored Meals (Gluten free, pureed) was estimated using waiver participant's assessment data available at the time related to chronic conditions which could possibly benefit from these services. Units per user factors in the service limits of 2 meals per day for 12 weeks for Medically Tailored Meals and Medically Tailored Meals (Gluten free, pureed) and service limit of 3 visits for Nutritional Counseling. Cost per unit is estimated at the reimbursement rate for these services. Rates for Medically Tailored Meals (MTMs) and Nutritional Counseling were established by looking at rates for the same/similar services provided in other State's Medicaid waivers or managed care programs and with input from existing CCW HDM providers qualified to offer MTMs and nutritional counseling.

Assistive Technology, Medically Tailored Meals, Nutritional Counseling, and Medically Tailored Meals (gluten free) are included as part of the State's approved HCBS Spending Plan authorized under Section 9817 of the ARPA through March 31, 2025 or until the State's authorized funding is exhausted. The state plans to amend the waiver to remove these services for WY2 - WY5 once the ARPA period has ended, comporting with the maintenance of effort requirement.

ARPA funding will be ending in March 2025. Therefore, those services funded by this source were adjusted to 9 months of utilization in WY1 and zero in future years. This includes Medically Tailored Meals, Medically Tailored Meals (gluten free, pureed), Nutritional Counseling, Assistive Technology – Procurement and Assistive

Technology.

Costs for Initial Plan of Care Development were calculated by estimating the number of new participants entering the waiver each year times the established rate for the service. Average units per user are limited to 1 per year.

All other services were based on analysis of FY17 – FY21 372 reports and\or utilization data.

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' reflects the average cost of non-waiver services that would otherwise be furnished to Community Choices waiver participants. All figures are based on the actual expenditures. Prescription drug costs associated with Medicare/Medicaid dual eligible participants are not contained in the report on which factor D' calculations are based.

Based on analysis of FY17 – FY21 actual expenditures reported in the 372 reports, annual change was calculated at 2.17%. Factor D' ranged between $5973 and $7930 during the look back period but did not follow an increasing or decreasing trend. Therefore, the inflation index for the first half of calendar year 2023 (1.5%) was used to estimate D' for future years.
https://data.bls.gov/timeseries/CUUR0000SAM?output_view=pct_12mths

Actuals From 372 Report	*FY17*	*FY18*	*FY19*	*FY20*	*FY21*
Factor D'	*$6,540.00*	*$6,694.00*	*$7,930.00*	*$7,879.00*	*$5,973.00*
% change over previous year		*2.35%*	*18.46%*	*-0.64%*	*-24.19%*

Annual Change -2.17%

Annual Change calculated as: (5973/6540 - 1) / 4 = -0.02%

Factor D' for WY2 – WY5 have been updated based on analysis of FY19 – FY23 actual expenditures reported in the 372 reports, annual change was calculated at 2.83%. Factor D' ranged between $5,973 and $8,829 during the look back period. WY2 was calculated using FY23 actuals and trending forward to FY26. Revised Factor D' estimates for WY3 – WY5 increase by 2.83% per year.

Actuals from 372 Report	*FY19*	*FY20*	*FY21*	*FY22*	*FY23*
Factor D'	*$7,930.00*	*$7,879.00*	*$5,973.00*	*$8,437.00*	*$8,829.00*
% change over previous year		*-0.64%*	*-24.19%*	*41.25%*	*4.65%*

Annual change: 2.83%

Annual change calculated as: (8829/7930 - 1) / 4

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 estimates are based on analysis of FY17 - FY21 actual expenditures reported in the 372 reports. Annual change in Factor G is calculated at 3.74%. The 3.74% annual inflation factor is applied for each year's estimates of Factor G.

Actuals from 372 Report	*FY17*	*FY18*	*FY19*	*FY20*	*FY21*
Factor G	*$37,140.00*	*$37,634.00*	*$40,476.00*	*$41,443.00*	*$42,697.00*
% Change over previous year		*1.33%*	*7.55%*	*2.39%*	*3.03%*

Annual Change 3.74%

Annual Change calculated as: (42697/37140 - 1) / 4 = 0.04%

Factor G estimates for WY2 – WY5 have been updated based on analysis of FY19 – FY23 actual expenditures reported in the 372 reports, annual change was calculated at 4.72%. Factor G ranged between $40,476 and $48,110 during the look back period. WY2 was calculated using FY23 actuals and trending forward to FY26. Revised Factor G estimates for WY3 – WY5 increase by 4.72% per year.

Actuals from 372 Report	*FY19*	*FY20*	*FY21*	*FY22*	*FY23*
Factor G	*$40,476.00*	*$41,443.00*	*$42,697.00*	*$46,449.00*	*$48,110.00*
% change over previous year		*2.39%*	*3.03%*	*8.79%*	*3.58%*

Annual change: 4.72%

Annual change calculated as: (48110/40476 - 1) / 4

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' reflects the average cost of non-facility services that would be otherwise furnished to nursing facility residents. All figures are based on actual expenditures. Prescription drug costs associated with Medicare/Medicaid dual eligible participants are not contained in the report on which factor G' calculation are based.

Based on analysis of FY17 – FY21 actual expenditures reported in the 372 reports, annual change was calculated at -0.53%. The change is negligible, thus no inflation factor is used for the estimates. Estimates for Factor G' are equal to actual Factor G' in the FY21 372 report.

Actuals from 372 Report FY17 FY18 FY19 FY20 FY21
Factor G' $5,424.00 $5,374.00 $5,517.00 $5,290.00 $5,309.00
% Change over previous year -0.92% 2.66% -4.11% 0.36%

Annual C -0.53%

Annual Change calculated as: (5309/5424 - 1) / 4 = -0.01%

Factor G' estimates for WY2 – WY5 have been updated based on analysis of FY19 – FY23 actual expenditures reported in the 372 reports, annual change was calculated at 3.55%. Factor G' ranged between $5,290 and $6,300 during the look back period. WY2 was calculated using FY23 actuals and trending forward to FY26. Revised Factor G' estimates for WY3 – WY5 increase by 3.55% per year.

Actuals from 372 Report FY19 FY20 FY21 FY22 FY23
Factor G' $5,517.00 $5,290.00 $5,309.00 $5,781.00 $6,300.00
% change over previous year -4.11% 0.36% 8.89% 8.98%

Annual change: 3.55%

Annual change calculated as: (6300/5517 - 1) / 4

Appendix J: Cost Neutrality Demonstration

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

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

Waiver Services	
Adult Day Health Care	
Caregiver Temporary Support Service	
Support Coordination	
Financial Management Services	
Assistive Devices and Medical Supplies	
Assistive Technology	
Environmental Accessibility Adaptation	
Home Delivered Meals	
Housing Stabilization Services	
Housing Transition or Crisis Intervention Services	
Monitored In-Home Caregiving	
Nursing	
Personal Assistance Services (PAS)	
Skilled Maintenance Therapy	
Transition Intensive Support Coordination	

Waiver Services	
Transition Service	

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:						**795357.00**
Adult Day Health Care	15 minutes	75	2638.00	4.02	**795357.00**	
Caregiver Temporary Support Service Total:						**27.78**
Center-Based Support Services, Overnight (by nursing facility and respite center)	daily w/overnight stay	0	0.00	141.36	**0.00**	
Center-Based Support Services, Overnight (by assisted living facility)	daily w/overnight stay	0	0.00	95.00	**0.00**	
Center-Based Support Services, Not Overnight (by ADHC)	15 minutes	0	0.00	4.02	**0.00**	
In-Home Support Services	15 minutes	2	3.00	4.63	**27.78**	
Support Coordination Total:						**15525720.00**
Initial Plan of Care Development	N/A	0	0.00	0.01	**0.00**	
Support Coordination	monthly	7686	10.00	202.00	**15525720.00**	
Financial Management Services Total:						**250829.72**
Financial Management Services	monthly	230	10.30	105.88	**250829.72**	

GRAND TOTAL: 258755616.25

Total Estimated Unduplicated Participants: 7908

Factor D (Divide total by number of participants): 32720.74

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Devices and Medical Supplies Total:						**830154.00**
Assistive Devices-Medical Supplied Procurement	per service	317	2.00	300.00	**190200.00**	
PERS	monthly	2608	9.00	27.00	**633744.00**	
Assistive Devices-Telecare-Health Status Monitoring-Equipment Installation and Removal	one time at installation	0	0.00	200.00	**0.00**	
PERS-installation	initial installation	207	1.00	30.00	**6210.00**	
Assistive Devices-TeleCare Activity & Sensor Monitoring-Monitoring Routine Maintenance & Rental	monthly	0	0.00	130.00	**0.00**	
Assistive Devices-Telecare-Medication Dispensing and Monitoring-Equipment Installation and Removal	one time at installation	0	0.00	25.00	**0.00**	
Assistive Devices -TeleCare Activity & Sensor Monitoring Equipment Installation & Removal	one time at installation	0	0.00	200.00	**0.00**	
Assistive Devices-Telecare-Medication Dispensing and Monitoring	monthly	0	0.00	40.00	**0.00**	
Assistive Devices-Telecare-Health Status Monitoring-Monitoring, Routine Maintenance and Rental	monthly	0	0.00	165.00	**0.00**	

GRAND TOTAL: 258755616.25

Total Estimated Unduplicated Participants: 7908

Factor D (Divide total by number of participants): 32720.74

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology Total:						**174500.00**
Assistive Technology - Procurement	per service	698	1.00	50.00	**34900.00**	
Assistive Technology	per service	698	1.00	200.00	**139600.00**	
Environmental Accessibility Adaptation Total:						**1151136.90**
EAA-Basic Assessment & Approval	per service	119	1.00	600.00	**71400.00**	
Environmental Accessibility Adaptation	per service	170	1.00	6267.57	**1065486.90**	
EAA-Final Inspection	per service	95	1.00	150.00	**14250.00**	
Home Delivered Meals Total:						**477741.32**
Medically Tailored Meals	per service	188	168.00	7.49	**236564.16**	
Nutritional Counseling	per service	188	3.00	49.00	**27636.00**	
Home Delivered Meals	per service	103	221.00	7.00	**159341.00**	
Medically Tailored Meals (Gluten free, pureed)	per service	38	168.00	8.49	**54200.16**	
Housing Stabilization Services Total:						**21758.40**
Housing Stabilization Services	15 minute	24	60.00	15.11	**21758.40**	
Housing Transition or Crisis Intervention Services Total:						**181.32**
Housing Transition or Crisis Intervention Services	15 minute	2	6.00	15.11	**181.32**	
Monitored In-Home Caregiving Total:						**2924325.32**
Monitored In-Home Caregiving, level 1	per day	89	292.00	78.63	**2043436.44**	
Monitored In-Home Caregiving-intake and assessment	per service	8	1.00	250.00	**2000.00**	

GRAND TOTAL: 258755616.25

Total Estimated Unduplicated Participants: 7908

Factor D (Divide total by number of participants): 32720.74

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Monitored In-Home Caregiving, level 2	per day	27	276.00	117.94	878888.88	
Nursing Total:						0.00
Nursing Care by R.N.	per visit	0	0.00	65.22	0.00	
Nursing Assessment by R.N.	per service	0	0.00	65.22	0.00	
Nursing Care by L.P.N.	per visit	0	0.00	58.00	0.00	
Nursing Assessment by L.P.N.	per service	0	0.00	58.00	0.00	
Personal Assistance Services (PAS) Total:						236167375.55
Personal Assistance Service (2 shared supports)	15 minutes	19	48916.00	4.07	3782674.28	
Personal Assistance Service-a.m./p.m., provided in the evening	per visit	2	4.00	39.12	312.96	
Personal Assistance Service	15 minutes	7095	6810.00	4.63	223707478.50	
Personal Assistance Service-a.m./p.m., provided in the morning	per visit	2	4.00	39.12	312.96	
Personal Assistance Service (3 shared supports)	15 minutes	0	0.00	3.73	0.00	
Consumer Directed Personal Assistance Service	15 minutes	255	7349.00	4.63	8676596.85	
Skilled Maintenance Therapy Total:						0.00
Occupational Therapy (assessment)	per service	0	0.00	77.50	0.00	
Speech-Language Therapy	per visit	0	0.00	77.50	0.00	
Speech-Language Therapy	per service	0	0.00	77.50	0.00	

GRAND TOTAL: 258755616.25

Total Estimated Unduplicated Participants: 7908

Factor D (Divide total by number of participants): 32720.74

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
(assessment)						
Physical Therapy	per visit	0	0.00	77.50	0.00	
Occupational Therapy	per visit	0	0.00	77.50	0.00	
Physical Therapy (assessment)	per service	0	0.00	77.50	0.00	
Transition Intensive Support Coordination Total:						287616.00
Transition Intensive Support Coordination	monthly	428	3.00	224.00	287616.00	
Transition Service Total:						148892.94
Transition Service	per service	126	1.00	1181.69	148892.94	

GRAND TOTAL: 258755616.25

Total Estimated Unduplicated Participants: 7908

Factor D (Divide total by number of participants): 32720.74

Average Length of Stay on the Waiver: 313

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:						848380.80
Adult Day Health Care	15 minutes	80	2638.00	4.02	848380.80	
Caregiver Temporary Support Service Total:						27.78
Center-Based Support Services, Overnight (by nursing facility and respite center)	daily w/overnight stay	0	0.00	141.36	0.00	

GRAND TOTAL: 278485996.89

Total Estimated Unduplicated Participants: 9381

Factor D (Divide total by number of participants): 29686.17

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Center-Based Support Services, Overnight (by assisted living facility)	Daily w/overnight stay	0	0.00	95.00	0.00	
Center-Based Support Services, Not Overnight (by ADHC)	15 minutes	0	0.00	4.02	0.00	
In-Home Support Services	15 minutes	2	3.00	4.63	27.78	
Support Coordination Total:						17422024.00
Initial Plan of Care Development	per initial plan	1328	1.00	530.50	704504.00	
Support Coordination	monthly	8276	10.00	202.00	16717520.00	
Financial Management Services Total:						298814.54
Financial Management Services	monthly	274	10.30	105.88	298814.54	
Assistive Devices and Medical Supplies Total:						892668.00
Assistive Devices-Medical Supplied Procurement	per service	341	2.00	300.00	204600.00	
PERS	per service	2806	9.00	27.00	681858.00	
Assistive Devices-Telecare-Health Status Monitoring-Equipment Installation and Removal	15 minutes	0	0.00	200.00	0.00	
PERS-installation	one time at installation	207	1.00	30.00	6210.00	
Assistive Devices-TeleCare Activity & Sensor Monitoring-Monitoring Routine Maintenance & Rental	per service	0	0.00	130.00	0.00	
Assistive Devices-Telecare-Medication	one time at installation	0	0.00	25.00	0.00	

GRAND TOTAL: 278485996.89

Total Estimated Unduplicated Participants: 9381

Factor D (Divide total by number of participants): 29686.17

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Dispensing and Monitoring-Equipment Installation and Removal						
Assistive Devices -TeleCare Activity & Sensor Monitoring Equipment Installation & Removal	one time at installation	0	0.00	200.00	0.00	
Assistive Devices-Telecare-Medication Dispensing and Monitoring	monthly	0	0.00	40.00	0.00	
Assistive Devices-Telecare-Health Status Monitoring-Monitoring, Routine Maintenance and Rental	per service	0	0.00	165.00	0.00	
Assistive Technology Total:						0.00
Assistive Technology - Procurement	per service	0	1.00	50.00	0.00	
Assistive Technology	per service	0	1.00	200.00	0.00	
Environmental Accessibility Adaptation Total:						1256269.14
EAA-Basic Assessment & Approval	per day	128	1.00	600.00	76800.00	
Environmental Accessibility Adaptation	per service	183	1.00	6361.58	1164169.14	
EAA-Final Inspection	15 minutes	102	1.00	150.00	15300.00	
Home Delivered Meals Total:						171717.00
Medically Tailored Meals	per service	0	168.00	7.49	0.00	
Nutritional Counseling	per service	0	3.00	49.00	0.00	
Home Delivered Meals	per service	111	221.00	7.00	171717.00	
Medically Tailored Meals (Gluten free, pureed)	per service	0	168.00	8.49	0.00	

GRAND TOTAL: 278485996.89

Total Estimated Unduplicated Participants: 9381

Factor D (Divide total by number of participants): 29686.17

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Housing Stabilization Services Total:						**23571.60**
Housing Stabilization Services	per service	26	60.00	15.11	**23571.60**	
Housing Transition or Crisis Intervention Services Total:						**181.32**
Housing Transition or Crisis Intervention Services	per visit	2	6.00	15.11	**181.32**	
Monitored In-Home Caregiving Total:						**3127437.96**
Monitored In-Home Caregiving, level 1	per visit	95	292.00	78.63	**2181196.20**	
Monitored In-Home Caregiving-intake and assessment	per visit	9	1.00	250.00	**2250.00**	
Monitored In-Home Caregiving, level 2	per day	29	276.00	117.94	**943991.76**	
Nursing Total:						**0.00**
Nursing Care by R.N.	per visit	0	0.00	65.22	**0.00**	
Nursing Assessment by R.N.	15 minutes	0	0.00	65.22	**0.00**	
Nursing Care by L.P.N.	15 minutes	0	0.00	58.00	**0.00**	
Nursing Assessment by L.P.N.	15 minutes	0	0.00	58.00	**0.00**	
Personal Assistance Services (PAS) Total:						**253976256.60**
Personal Assistance Service (2 shared supports)	per visit	20	48916.00	4.07	**3981762.40**	
Personal Assistance Service-a.m./p.m., provided in the evening	per service	2	4.00	39.12	**312.96**	
Personal Assistance Service	per visit	7633	6810.00	4.63	**240670779.90**	
Personal					**312.96**	

GRAND TOTAL: 278485996.89

Total Estimated Unduplicated Participants: 9381

Factor D (Divide total by number of participants): 29686.17

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistance Service- a.m./p.m., provided in the morning	per service	2	4.00	39.12		
Personal Assistance Service (3 shared supports)	15 minutes	0	0.00	3.73	0.00	
Consumer Directed Personal Assistance Service	per visit	274	7349.00	4.63	9323088.38	
Skilled Maintenance Therapy Total:						0.00
Occupational Therapy (assessment)	per service	0	0.00	77.50	0.00	
Speech-Language Therapy	per visit	0	0.00	77.50	0.00	
Speech-Language Therapy (assessment)	per service	0	0.00	77.50	0.00	
Physical Therapy	per visit	0	0.00	77.50	0.00	
Occupational Therapy	per visit	0	0.00	77.50	0.00	
Physical Therapy (assessment)	per service	0	0.00	77.50	0.00	
Transition Intensive Support Coordination Total:						309120.00
Transition Intensive Support Coordination	monthly	460	3.00	224.00	309120.00	
Transition Service Total:						159528.15
Transition Service	per service	135	1.00	1181.69	159528.15	

GRAND TOTAL: 278485996.89

Total Estimated Unduplicated Participants: 9381

Factor D (Divide total by number of participants): 29686.17

Average Length of Stay on the Waiver: 313

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 3

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Adult Day Health Care Total:						***848380.80***
Adult Day Health Care	*15 minutes*	*80*	*2638.00*	*4.02*	***848380.80***	
Caregiver Temporary Support Service Total:						***27.78***
Center-Based Support Services, Overnight (by nursing facility and respite center)	*daily w/overnight stay*	*0*	*0.00*	*141.36*	***0.00***	
Center-Based Support Services, Overnight (by assisted living facility)	*Daily w/overnight stay*	*0*	*0.00*	*95.00*	***0.00***	
Center-Based Support Services, Not Overnight (by ADHC)	*15 minutes*	*0*	*0.00*	*4.02*	***0.00***	
In-Home Support Services	*15 minutes*	*2*	*3.00*	*4.63*	***27.78***	
Support Coordination Total:						***17422024.00***
Initial Plan of Care Development	*per initial plan*	*1328*	*1.00*	*530.50*	***704504.00***	
Support Coordination	*monthly*	*8276*	*10.00*	*202.00*	***16717520.00***	
Financial Management Services Total:						***298814.54***
Financial Management Services	*monthly*	*274*	*10.30*	*105.88*	***298814.54***	
Assistive Devices and Medical Supplies Total:						***892668.00***
Assistive Devices-Medical Supplied Procurement	*per service*	*341*	*2.00*	*300.00*	***204600.00***	
PERS	*monthly*	*2806*	*9.00*	*27.00*	***681858.00***	
Assistive Devices-Telecare-Health Status Monitoring-Equipment Installation and	*one time at installation*	*0*	*0.00*	*200.00*	***0.00***	

GRAND TOTAL: ***278503458.75***

Total Estimated Unduplicated Participants: ***9381***

Factor D (Divide total by number of participants): ***29688.04***

Average Length of Stay on the Waiver: *313*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Removal						
PERS-installation	initial installation	207	1.00	30.00	6210.00	
Assistive Devices-TeleCare Activity & Sensor Monitoring-Monitoring Routine Maintenance & Rental	monthly	0	0.00	130.00	0.00	
Assistive Devices-Telecare-Medication Dispensing and Monitoring-Equipment Installation and Removal	one time at installation	0	0.00	25.00	0.00	
Assistive Devices -TeleCare Activity & Sensor Monitoring Equipment Installation & Removal	one time at installation	0	0.00	200.00	0.00	
Assistive Devices-Telecare-Medication Dispensing and Monitoring	monthly	0	0.00	40.00	0.00	
Assistive Devices-Telecare-Health Status Monitoring-Monitoring, Routine Maintenance and Rental	monthly	0	0.00	165.00	0.00	
Assistive Technology Total:						0.00
Assistive Technology - Procurement	per service	0	1.00	50.00	0.00	
Assistive Technology	per service	0	1.00	200.00	0.00	
Environmental Accessibility Adaptation Total:						1273731.00
EAA-Basic Assessment & Approval	per service	128	1.00	600.00	76800.00	
Environmental Accessibility Adaptation	per service	183	1.00	6457.00	1181631.00	

GRAND TOTAL: 278503458.75

Total Estimated Unduplicated Participants: 9381

Factor D (Divide total by number of participants): 29688.04

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
EAA-Final Inspection	per service	102	1.00	150.00	15300.00	
Home Delivered Meals Total:						171717.00
Medically Tailored Meals	per service	0	168.00	7.49	0.00	
Nutritional Counseling	per service	0	3.00	49.00	0.00	
Home Delivered Meals	per service	111	221.00	7.00	171717.00	
Medically Tailored Meals (Gluten free, pureed)	per service	0	168.00	8.49	0.00	
Housing Stabilization Services Total:						23571.60
Housing Stabilization Services	15 minutes	26	60.00	15.11	23571.60	
Housing Transition or Crisis Intervention Services Total:						181.32
Housing Transition or Crisis Intervention Services	15 minuttes	2	6.00	15.11	181.32	
Monitored In-Home Caregiving Total:						3127437.96
Monitored In-Home Caregiving, level 1	per day	95	292.00	78.63	2181196.20	
Monitored In-Home Caregiving-intake and assessment	per service	9	1.00	250.00	2250.00	
Monitored In-Home Caregiving, level 2	per day	29	276.00	117.94	943991.76	
Nursing Total:						0.00
Nursing Care by R.N.	per visit	0	0.00	65.22	0.00	
Nursing Assessment by R.N.	per service	0	0.00	65.22	0.00	
Nursing Care by L.P.N.	per visit	0	0.00	58.00	0.00	
Nursing Assessment by L.P.N.	per service	0	0.00	58.00	0.00	

GRAND TOTAL: 278503458.75

Total Estimated Unduplicated Participants: 9381

Factor D (Divide total by number of participants): 29688.04

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Assistance Services (PAS) Total:						**253976256.60**
Personal Assistance Service (2 shared supports)	15 minutes	20	48916.00	4.07	**3981762.40**	
Personal Assistance Service-a.m./p.m., provided in the evening	per visit	2	4.00	39.12	**312.96**	
Personal Assistance Service	15 minutes	7633	6810.00	4.63	**240670779.90**	
Personal Assistance Service-a.m./p.m., provided in the morning	per visit	2	4.00	39.12	**312.96**	
Personal Assistance Service (3 shared supports)	15 minutes	0	0.00	3.73	**0.00**	
Consumer Directed Personal Assistance Service	15 minutes	274	7349.00	4.63	**9323088.38**	
Skilled Maintenance Therapy Total:						**0.00**
Occupational Therapy (assessment)	per service	0	0.00	77.50	**0.00**	
Speech-Language Therapy	per visit	0	0.00	77.50	**0.00**	
Speech-Language Therapy (assessment)	per service	0	0.00	77.50	**0.00**	
Physical Therapy	per visit	0	0.00	77.50	**0.00**	
Occupational Therapy	per visit	0	0.00	77.50	**0.00**	
Physical Therapy (assessment)	per service	0	0.00	77.50	**0.00**	
Transition Intensive Support Coordination Total:						**309120.00**
Transition Intensive Support Coordination	monthly	460	3.00	224.00	**309120.00**	

GRAND TOTAL: 278503458.75

Total Estimated Unduplicated Participants: 9381

Factor D (Divide total by number of participants): 29688.04

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transition Service Total:						**159528.15**
Transition Service	per service	135	1.00	1181.69	**159528.15**	

GRAND TOTAL: 278503458.75
Total Estimated Unduplicated Participants: 9381
Factor D (Divide total by number of participants): 29688.04
Average Length of Stay on the Waiver: 313

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:						**848380.80**
Adult Day Health Care	15 minutes	80	2638.00	4.02	**848380.80**	
Caregiver Temporary Support Service Total:						**27.78**
Center-Based Support Services, Overnight (by nursing facility and respite center)	daily w/overnight stay	0	0.00	141.36	**0.00**	
Center-Based Support Services, Overnight (by assisted living facility)	daily w/overnight stay	0	0.00	95.00	**0.00**	
Center-Based Support Services, Not Overnight (by ADHC)	15 minutes	0	0.00	4.02	**0.00**	
In-Home Support Services	15 minutes	2	3.00	4.63	**27.78**	
Support Coordination Total:						**17422024.00**
Initial Plan of Care					**704504.00**	

GRAND TOTAL: 278521184.13
Total Estimated Unduplicated Participants: 9381
Factor D (Divide total by number of participants): 29689.92
Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Development	per initial plan	1328	1.00	530.50		
Support Coordination	monthly	8276	10.00	202.00	16717520.00	
Financial Management Services Total:						298814.54
Financial Management Services	monthly	274	10.30	105.88	298814.54	
Assistive Devices and Medical Supplies Total:						892668.00
Assistive Devices-Medical Supplied Procurement	per service	341	2.00	300.00	204600.00	
PERS	monthly	2806	9.00	27.00	681858.00	
Assistive Devices-Telecare-Health Status Monitoring-Equipment Installation and Removal	one time at installation	0	0.00	200.00	0.00	
PERS-installation	initial installation	207	1.00	30.00	6210.00	
Assistive Devices-TeleCare Activity & Sensor Monitoring-Monitoring Routine Maintenance & Rental	monthly	0	0.00	130.00	0.00	
Assistive Devices-Telecare-Medication Dispensing and Monitoring-Equipment Installation and Removal	one time at installation	0	0.00	25.00	0.00	
Assistive Devices -TeleCare Activity & Sensor Monitoring Equipment Installation & Removal	one time at installation	0	0.00	200.00	0.00	
Assistive Devices-Telecare-Medication	monthly	0	0.00	40.00	0.00	

GRAND TOTAL: 278521184.13

Total Estimated Unduplicated Participants: 9381

Factor D (Divide total by number of participants): 29689.92

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Dispensing and Monitoring						
Assistive Devices-Telecare-Health Status Monitoring-Monitoring, Routine Maintenance and Rental	monthly	0	0.00	165.00	0.00	
Assistive Technology Total:						0.00
Assistive Technology - Procurement	one time	0	1.00	50.00	0.00	
Assistive Technology	one time	0	1.00	200.00	0.00	
Environmental Accessibility Adaptation Total:						1291456.38
EAA-Basic Assessment & Approval	per service	128	1.00	600.00	76800.00	
Environmental Accessibility Adaptation	per service	183	1.00	6553.86	1199356.38	
EAA-Final Inspection	per service	102	1.00	150.00	15300.00	
Home Delivered Meals Total:						171717.00
Medically Tailored Meals	per service	0	168.00	7.49	0.00	
Nutritional Counseling	per service	0	3.00	49.00	0.00	
Home Delivered Meals	per service	111	221.00	7.00	171717.00	
Medically Tailored Meals (Gluten free, pureed)	per service	0	168.00	8.49	0.00	
Housing Stabilization Services Total:						23571.60
Housing Stabilization Services	15 minute	26	60.00	15.11	23571.60	
Housing Transition or Crisis Intervention Services Total:						181.32
Housing Transition or Crisis Intervention Services	15 minute	2	6.00	15.11	181.32	

GRAND TOTAL: 278521184.13

Total Estimated Unduplicated Participants: 9381

Factor D (Divide total by number of participants): 29689.92

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Monitored In-Home Caregiving Total:						**3127437.96**
Monitored In-Home Caregiving, level 1	per day	95	292.00	78.63	**2181196.20**	
Monitored In-Home Caregiving-intake and assessment	per service	9	1.00	250.00	**2250.00**	
Monitored In-Home Caregiving, level 2	per day	29	276.00	117.94	**943991.76**	
Nursing Total:						**0.00**
Nursing Care by R.N.	per visit	0	0.00	65.22	**0.00**	
Nursing Assessment by R.N.	per service	0	0.00	65.22	**0.00**	
Nursing Care by L.P.N.	per visit	0	0.00	58.00	**0.00**	
Nursing Assessment by L.P.N.	per service	0	0.00	58.00	**0.00**	
Personal Assistance Services (PAS) Total:						**253976256.60**
Personal Assistance Service (2 shared supports)	15 minutes	20	48916.00	4.07	**3981762.40**	
Personal Assistance Service-a.m./p.m., provided in the evening	per visit	2	4.00	39.12	**312.96**	
Personal Assistance Service	15 minutes	7633	6810.00	4.63	**240670779.90**	
Personal Assistance Service-a.m./p.m., provided in the morning	per visit	2	4.00	39.12	**312.96**	
Personal Assistance Service (3 shared supports)	15 minutes	0	0.00	3.73	**0.00**	
Consumer Directed Personal Assistance Service	15 minutes	274	7349.00	4.63	**9323088.38**	
Skilled						**0.00**

GRAND TOTAL: 278521184.13

Total Estimated Unduplicated Participants: 9381

Factor D (Divide total by number of participants): 29689.92

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Maintenance Therapy Total:						
Occupational Therapy (assessment)	per service	0	0.00	77.50	**0.00**	
Speech-Language Therapy	per visit	0	0.00	77.50	**0.00**	
Speech-Language Therapy (assessment)	per service	0	0.00	77.50	**0.00**	
Physical Therapy	per visit	0	0.00	77.50	**0.00**	
Occupational Therapy	per visit	0	0.00	77.50	**0.00**	
Physical Therapy (assessment)	per service	0	0.00	77.50	**0.00**	
Transition Intensive Support Coordination Total:						**309120.00**
Transition Intensive Support Coordination	monthly	460	3.00	224.00	**309120.00**	
Transition Service Total:						**159528.15**
Transition Service	per service	135	1.00	1181.69	**159528.15**	

GRAND TOTAL: 278521184.13
Total Estimated Unduplicated Participants: 9381
Factor D (Divide total by number of participants): 29689.92
Average Length of Stay on the Waiver: 313

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:						**848380.80**
Adult Day Health Care					**848380.80**	

GRAND TOTAL: 278539174.86
Total Estimated Unduplicated Participants: 9381
Factor D (Divide total by number of participants): 29691.84
Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 minutes	80	2638.00	4.02		
Caregiver Temporary Support Service Total:						**27.78**
Center-Based Support Services, Overnight (by nursing facility and respite center)	daily w/overnight stay	0	0.00	141.36	**0.00**	
Center-Based Support Services, Overnight (by assisted living facility)	daily w/overnight stay	0	0.00	95.00	**0.00**	
Center-Based Support Services, Not Overnight (by ADHC)	15 minutes	0	0.00	4.02	**0.00**	
In-Home Support Services	15 minutes	2	3.00	4.63	**27.78**	
Support Coordination Total:						**17422024.00**
Initial Plan of Care Development	per initial plan	1328	1.00	530.50	**704504.00**	
Support Coordination	monthly	8276	10.00	202.00	**16717520.00**	
Financial Management Services Total:						**298814.54**
Financial Management Services	monthly	274	10.30	105.88	**298814.54**	
Assistive Devices and Medical Supplies Total:						**892668.00**
Assistive Devices-Medical Supplied Procurement	per service	341	2.00	300.00	**204600.00**	
PERS	monthly	2806	9.00	27.00	**681858.00**	
Assistive Devices-Telecare-Health Status Monitoring-Equipment Installation and Removal	one time at installation	0	0.00	200.00	**0.00**	
PERS-installation	initial installation	207	1.00	30.00	**6210.00**	
Assistive					**0.00**	

GRAND TOTAL: 278539174.86

Total Estimated Unduplicated Participants: 9381

Factor D (Divide total by number of participants): 29691.84

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Devices-TeleCare Activity & Sensor Monitoring-Monitoring Routine Maintenance & Rental	monthly	0	0.00	130.00		
Assistive Devices-Telecare-Medication Dispensing and Monitoring-Equipment Installation and Removal	one time at installation	0	0.00	25.00	0.00	
Assistive Devices -TeleCare Activity & Sensor Monitoring Equipment Installation & Removal	one time at installation	0	0.00	200.00	0.00	
Assistive Devices-Telecare-Medication Dispensing and Monitoring	monthly	0	0.00	40.00	0.00	
Assistive Devices-Telecare-Health Status Monitoring-Monitoring, Routine Maintenance and Rental	monthly	0	0.00	165.00	0.00	
Assistive Technology Total:						0.00
Assistive Technology - Procurement	one time	0	1.00	50.00	0.00	
Assistive Technology	one time	0	1.00	200.00	0.00	
Environmental Accessibility Adaptation Total:						1309447.11
EAA-Basic Assessment & Approval	per service	128	1.00	600.00	76800.00	
Environmental Accessibility Adaptation	per service	183	1.00	6652.17	1217347.11	
EAA-Final Inspection	per service	102	1.00	150.00	15300.00	
Home Delivered Meals Total:						171717.00

GRAND TOTAL: 278539174.86

Total Estimated Unduplicated Participants: 9381

Factor D (Divide total by number of participants): 29691.84

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medically Tailored Meals	per service	0	168.00	7.49	0.00	
Nutritional Counseling	per service	0	3.00	49.00	0.00	
Home Delivered Meals	per service	111	221.00	7.00	171717.00	
Medically Tailored Meals (Gluten free, pureed)	per service	0	168.00	8.49	0.00	
Housing Stabilization Services Total:						23571.60
Housing Stabilization Services	15 minute	26	60.00	15.11	23571.60	
Housing Transition or Crisis Intervention Services Total:						181.32
Housing Transition or Crisis Intervention Services	15 minute	2	6.00	15.11	181.32	
Monitored In-Home Caregiving Total:						3127437.96
Monitored In-Home Caregiving, level 1	per day	95	292.00	78.63	2181196.20	
Monitored In-Home Caregiving-intake and assessment	per service	9	1.00	250.00	2250.00	
Monitored In-Home Caregiving, level 2	per day	29	276.00	117.94	943991.76	
Nursing Total:						0.00
Nursing Care by R.N.	per visit	0	0.00	65.22	0.00	
Nursing Assessment by R.N.	per service	0	0.00	65.22	0.00	
Nursing Care by L.P.N.	per visit	0	0.00	58.00	0.00	
Nursing Assessment by L.P.N.	per service	0	0.00	58.00	0.00	
Personal Assistance Services (PAS) Total:						253976256.60
Personal					3981762.40	

GRAND TOTAL: 278539174.86

Total Estimated Unduplicated Participants: 9381

Factor D (Divide total by number of participants): 29691.84

Average Length of Stay on the Waiver: 313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistance Service (2 shared supports)	15 minutes	20	48916.00	4.07		
Personal Assistance Service-a.m./p.m., provided in the evening	per visit	2	4.00	39.12	312.96	
Personal Assistance Service	15 minutes	7633	6810.00	4.63	240670779.90	
Personal Assistance Service-a.m./p.m., provided in the morning	per visit	2	4.00	39.12	312.96	
Personal Assistance Service (3 shared supports)	15 minutes	0	0.00	3.73	0.00	
Consumer Directed Personal Assistance Service	15 minutes	274	7349.00	4.63	9323088.38	
Skilled Maintenance Therapy Total:						0.00
Occupational Therapy (assessment)	per service	0	0.00	77.50	0.00	
Speech-Language Therapy	per visit	0	0.00	77.50	0.00	
Speech-Language Therapy (assessment)	per service	0	0.00	77.50	0.00	
Physical Therapy	per visit	0	0.00	77.50	0.00	
Occupational Therapy	per visit	0	0.00	77.50	0.00	
Physical Therapy (assessment)	per service	0	0.00	77.50	0.00	
Transition Intensive Support Coordination Total:						309120.00
Transition Intensive Support Coordination	monthly	460	3.00	224.00	309120.00	
Transition Service Total:						159528.15
Transition Service	per service	135	1.00	1181.69	159528.15	

GRAND TOTAL: 278539174.86

Total Estimated Unduplicated Participants: 9381

Factor D (Divide total by number of participants): 29691.84

Average Length of Stay on the Waiver: 313