

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

A. The State of 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:

Residential Options Waiver (ROW)

C. Waiver Number: LA.0472

D. Amendment Number:

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

07/01/15

Approved Effective Date of Waiver being Amended: 07/01/13

2. Purpose(s) of Amendment

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

To identify a reserved capacity group allowing individuals with current OCDD Statement of Approvals to transition from OAAS Community Choice and/or Adult Day Health Care Waiver programs to the Residential Options Waiver (ROW), as OAAS moves to Managed Care.

3. Nature of the Amendment

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

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

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

☐ Modify target group(s)

☐ Modify Medicaid eligibility

☐ Add/delete services

☐ Revise service specifications

- ☐ Revise provider qualifications
- ☐ Increase/decrease number of participants
- ☐ Revise cost neutrality demonstration
- ☐ Add participant-direction of services
- ☐ Other

Specify:

To ensure OAAS waiver participants receive the most appropriate services and care management under managed care, any individual with intellectual and developmental disabilities (I/DD) who is receiving OAAS Community Choice Wavier (CCW) services will be transitioned to the Residential Options Waiver (ROW)

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

1. Request Information (1 of 3)

- A.** The State of Louisiana requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. Program Title** (optional - this title will be used to locate this waiver in the finder):
Residential Options Waiver (ROW)
- 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.005.01.03

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

Regular Waiver ☒

- E. Proposed Effective Date of Waiver being Amended:** 10/01/12
Approved Effective Date of Waiver being Amended: 07/01/13

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 §1915(a)(1)(a) of the Act and described in Appendix I

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

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

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

☐ §1915(b)(1) (mandated enrollment to managed care)

☐ §1915(b)(2) (central broker)

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

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

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

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

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

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

☐ A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

☒ This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

Brief Waiver Description. In one page or less, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The purpose of the Residential Options Waiver, a 1915 C waiver, is to assist service participants in leading healthy, independent and productive lives to the fullest extent possible; promote the full exercise of their rights as citizens of the state of Louisiana; and promote the integrity and well-being of their families. Services are provided with the goal of promoting independence through strengthening the participant's capacity for self-care and self-sufficiency. The Residential Options Waiver is person-centered incorporating the participant's support needs and preferences with a goal of integrating the participant into their community. The Residential Options Waiver provides opportunities for individuals with developmental disabilities to transition from ICFs-DD into home and community based services by providing residential and support services.

The objectives of the Residential Options Waiver are to:

- Promote independence for participants through the provision of services meeting the highest standards of quality and national best practices, while ensuring health and safety through a comprehensive system of participant safeguards;
- Offer an alternative to institutionalization and costly comprehensive services through the provision of an array of services and supports that promote community inclusion and independence by enhancing and not replacing existing informal networks;
- Support participants and their families to exercise their rights and share responsibility for their programs regardless of the method of service delivery; and
- Offer access to services on a short-term basis which would protect the health and safety of the participant in the event that the family or other caregiver were unable to continue to provide care and supports.

The Department of Health and Hospitals (DHH) Bureau of Health Services Financing is the Single State Medicaid Agency which maintains administrative and supervisory oversight of the Residential Options Waiver. BHSF (Medicaid) has a Memorandum of Understanding with the Districts and Authorities, along with the Office for Citizens with Developmental Disabilities, which specifies the roles and responsibilities of each party and the methods BHSF will use to ensure the operating agency performs delegated waiver operations and administrative functions in accordance with the approved waiver application, rules, and policies. This agreement has been in effect since 2010.

Services are accessed through a single point of entry within OCDD Regional Waiver Supports and Services Offices until which time the single point of entry is taken over by Human Services Authorities or Districts per a proposed timeline. All waiver participants choose their Support Coordination and Direct Service Provider Agencies through the Freedom of Choice process. All services must be prior authorized and delivered in accordance with an approved Plan of Care. The Plan of Care is approved at the OCDD Regional Waiver Supports and Services Offices until which time this role is taken over by Human Services Authorities per a proposed timeline. Prior authorization is completed through an independent entity contracted by DHH that also maintains the service data on all waivers for the developmental disabilities population.

The ROW includes Participant Direction of Services as an optional service delivery method. The participant-directed service is Community Living Supports.

3. Components of the Waiver Request

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

- A. **Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. **Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. **Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. **Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. **Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*
- ☒ **Yes. This waiver provides participant direction opportunities.** Appendix E is required.
- ☐ **No. This waiver does not provide participant direction opportunities.** Appendix E is not required.
- F. **Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. **Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. **Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. **Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. **Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:
- ☐ Not Applicable
- ☒ No
- ☐ Yes
- C. **Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act *(select one)*:
- ☒ No
- ☐ Yes

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

- ☐ **Geographic Limitation.** A waiver of statewide 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 statewide is requested in order to make participant-direction of services as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

- A. **Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. **Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Method 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 §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:
Public input was included in development of the waiver by establishment of a statewide ROW Stakeholder Workgroup. The Workgroup members were chosen at a statewide stakeholder roll-out meeting on the ROW pursuant to an invitational letter requesting representatives from each of the following groups:
- Family, Advocacy, State Advisory and other developmental disability organizations such as the Developmental Disabilities Planning Council, the State Protection and Advocacy Agency, the Community Living Ombudsman Program, ARC of LA, AAMR of LA, Families Helping Families of LA and the LA. Rehabilitation Services;
 - Individuals with disabilities and family members, especially those persons waiting for waiver services and current residents of ICFs-DD interested in moving into less restrictive residential waiver options;
 - ICFs-DD Waiver and Support Coordination provider organizations; and
 - Regional Administrative Units, Supports and Services Centers, State Medicaid and OCDD State Office representatives.

A group of Core Stakeholders was drafted at the initial meeting to assist with service criteria and definitions, target group identifications, rates etc. The Workgroup members were also asked to relay feedback and promote two-way communication between their constituents in the various stakeholder groups. Additionally, they were specifically asked to communicate issues, concerns and recommendations from the various stakeholder groups to the OCDD staff assigned to complete the ROW application.

During meetings and listening sessions, questions and comments were solicited regarding waiver services and processes. The application renewal took into account information obtained from the meetings/listening sessions. Information discussed in the meetings included vocational services, provider capacity, self-direction, etc. Meeting participants were able to discuss what was working well in the program and what needed changing. Included in the meetings/listening sessions were consumers, parents of consumers, Families Helping Families organization, Louisiana Advocacy Center, Developmental Disability Council, Louisiana Workforce Commission, Department of Education, Louisiana Rehabilitation Services, Louisiana State University Health Sciences Center, and providers. Louisiana has become an Employment 1st state and is in the process developing policy and processes to reflect the changing ideals. Louisiana is in the process of finalizing supported employment definitions, services rates, and services units. This information will be updated in OCDD waiver applications once the Employment 1st consortium has completed revising employment definitions and developing a plan of implementation. Identification of additional provider types available in the state was also identified and included in the application renewal. Dates include October 11, 13, 18, 19, 25, 27, November 30, and December 2, 14, 15, 2011.

- 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 assure 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:

Levelle

First Name:

Jeanne

Title:

Section Chief

Agency:

Bureau of Health Services Financing

Address:

628 N. 4th Street

Address 2:

P.O. Box 91030

City:

Baton Rouge

State:

Louisiana

Zip:

70821

Phone:

(225) 342-9846

Ext:

☐ TTY

Fax:

(225) 342-9168

E-mail:

jeanne.levelle@la.gov

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

Last Name:

Thomas

First Name:

Mark

Title:

Assistant Secretary

Agency:

Office for Citizens with Developmental Disabilities

Address:

628 N. 4th Street

Address 2:

City:

Baton Rouge

State:

Louisiana

Zip:

Phone: _____
70821

Fax: 8. _____

Authorizing Signature

(225) 342-0095

Ext: ☐ TTY

E-mail: This _____

document, together with the (225) 342-8823

attached revisions to the affected components of the waiver,

constitutes the State's request to

amend its approved waiver under Mark.thomas@LA.GOV

§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: _____

State Medicaid Director or Designee

Submission Date: _____

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

Last Name: _____

First Name: _____

Title: _____

Agency: _____

Address: _____

Address 2: _____

City: _____

State: Louisiana

Zip: _____

Phone: _____

Ext: ☐ TTY

Fax: _____

E-mail: _____

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:

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

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

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones. To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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:

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:
The State Medicaid Agency, BHSF, and the operating agency OCDD, have a Memorandum of Understanding (MOU) defining the responsibilities of each. The MOU is to be reviewed yearly and updated as necessary. To ensure compliance with federal regulations governing waivers, BHSF created the Waiver Assistance and Compliance Section (WCS) to oversee the administration of all Medicaid waiver programs within Louisiana. Monitoring is completed under the direction of the Waiver Compliance Program Manager.
- BHSF and OCDD 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 interagency agreement requires BHSF and OCDD to:
- meet quarterly to evaluate the waiver program and initiate necessary changes to policy and/or reimbursement rates
 - meet quarterly with the Division of Health Economics to review the financial accountability reports for the waiver program
- BHSF through WCS facilitates semi-monthly meetings with OCDD and the Medicaid data contractor to discuss waiver issues and problems. At these meetings, solutions are formed, corrective action agreed upon, and follow-up implemented by OCDD as necessary. In addition, meetings are held at least quarterly with WCS, the Medicaid Director or Deputy Director, the OCDD Assistant Secretary, and other designated staff to discuss problems, issues, planning, concerns, and any other matters concerning the waiver as necessary. Variance meetings are also held monthly with OCDD, DHH's Division of Health Economics, and WCS to review financial utilization and expenditure performance of all OCDD' waivers.
- BHSF retains oversight of all waiver operations and administrative functions performed by the operating agency. In furtherance of carrying out the interagency agreement and under the authority of BHSF, the following activities occur:
1. Disseminate information concerning the waiver to potential enrollees – Frequent and regular meetings are held between OCDD and WCS where proposed changes are discussed prior to OCDD developing drafts. Drafts are submitted to WCS for our input and suggestions. Revisions are made accordingly until a final draft is completed for Medicaid review and approval. As needed, WCS will participate in training conducted by OCDD when implementing changes with providers. BHSF develops and distributes brochures, flyers, and other informational material regarding available programs to Louisiana citizens. BHSF oversees the website information, as well as communication distribution via Help Lines regarding waiver eligibility and policy administration.
 2. Assist individuals in waiver enrollment – BHSF maintains supervision by approving the process for entry of individuals into the waiver through the OCDD regional office and post-linkage procedures carried out by OCDD and the contractors.
 3. Manage waiver enrollment against approved limits – BHSF receives bi-weekly reports from the Medicaid data contractor which identify the number of participants receiving services, exiting the waiver, and offered a waiver opportunity. This report is reviewed with OCDD during the bi-weekly meetings. Other reports which are received by both BHSF and OCDD include waiver closure summary reports, admissions summary reports, level of care intake, acute care utilization, and waiver expenditures.
 4. Monitor waiver expenditures against approved limits – OCDD is responsible for completing the annual CMS-372 report utilizing MMIS data and submitting it to BHSF for review and approval. Quarterly meetings with BHSF, OCDD, and the Division of Health Economics are held to discuss waiver administration and to review financial participation and budget forecasts in order to determine if any adjustments are needed.
 5. Conduct level of care evaluation activities – OCDD is responsible for submitting aggregated reports on level of care assurances to BHSF on a quarterly basis. In addition, the Medicaid data contractor submits reports to BHSF on the number of initial enrollees who meet the required level of care prior to receipt of services and the number of participants who received an annual redetermination at least annually.
 6. Review participant service plans to ensure that all waiver requirements are met – OCDD is responsible for submitting aggregated reports on plan of care assurances to BHSF on an established basis. In addition, the Medicaid data contractor submits reports to

BHSF on the number of service plans updated/revised at least annually, 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.

7. Prior authorize waiver services – BHSF oversees OCDD's exercise of prior authorization activities through reports issued by the Medicaid data contractor. Bi-weekly meetings are held with BHSF, OCDD, and the Medicaid data contractor to discuss any issues relevant to prior authorization. BHSF ensures waiver services are authorized and utilized in conformance to waiver requirements through the annual monitoring conducted during the licensing surveys and random audits of the plans of care. System changes related to claims processing and prior authorization can only be facilitated by BHSF.

8. Determine waiver payment amounts or rates - BHSF determines all waiver payment amounts/rates in collaboration with OCDD, Division of Health Economics, and as necessary the Rate & Audit section.

9. Conduct training and technical assistance concerning waiver requirements – The Medicaid fiscal intermediary conducts annual training related to Medicaid requirements with prior approval from BHSF on all material. BHSF also reviews all OCDD waiver policies and satisfaction survey results as it relates.

BHSF's Health Standards Section conducts all licensing surveys of providers that render waiver services.

Among the numerous reports generated by the Medicaid data contractor and provided to BHSF/WCS for oversight are the following: number of individuals linked to each support coordination agency by waiver; waiver offers in process but not yet certified; number of recipients assigned to each support coordinator; direct service workers report; number of waiver closures by type; timeliness of annual plans of care; tracking timeliness, accuracy, and approval of plans of care; pre and post authorization report; individuals listed on the Request for Services Registry; waiver offers made and accepted; days from linkage to support coordination agency to plan of care submission and approval; authorized and released amounts for waiver caps; authorized and released amount by procedure codes; and unduplicated waiver counts.

These reports disclose the status of the waiver operation on a day-to-day basis. Reports may reveal such things as LOC determination and whether or not they are being performed timely and appropriately, as defined by policy. Training reports provide information on frequency and attendance. Other reports provide information on waiver utilization. By review of these reports and meetings with the operating agency, BHSF exercises administrative authority by seeking information and solutions on discrepancies, areas needing improvement, as well as observing areas that are working well in the waiver on a day-to-day basis.

Additionally, WCS receives monthly Program Integrity reports for aberrant billing practices and enrollment, as well as ongoing reports from Health Standards regarding provider licensing and certification, and annual reports on waiver monitoring.

WCS reviews the reports from the operating agency, fiscal agent, point of entry contractor, and data contractor to determine if the results indicate areas of non-compliance. WCS will pursue a series of corrective actions including requiring or conducting additional training and increasing the level of departmental involvement in the decision-making process.

There are several cross agency workgroups which have been formed in order to improve the Quality Improvement System within many Medicaid Waivers, including the Residential Opportunities waiver.

The Cross-Waiver Executive Management Team is held monthly with the Medicaid Director, Deputy Medicaid Director, and OCDD Assistant Secretary, WCS, OCDD and other relevant staff to discuss planning, budgetary matters, compliance issues, technical assistance, and other issues that affect the Medicaid waivers. This group serves to: adopt quality standards and measures for HCBS Waivers; oversee the performance of the HCBS waivers to assure their effectiveness, efficiency, and integration; evaluate performance reports; take action on recommendations from other Cross-Waiver Quality Teams/Workgroups; and trouble shoot critical issues.

The Cross-Waiver Stakeholder Advisory Committee meets twice a year and includes members of WCS, State Operating Agencies, consumer, providers, and advocates. In these meetings, HCBS quality measures are identified and assessed for updates, performance data is evaluated, and quality improvement initiatives are advised.

The Cross-Waiver Quality Review Team meets every other month and is composed of quality, programmatic & IT representatives from the Program Offices, Medicaid, and DHH IT. This team reports to the Cross-Waiver Executive Management Team. Among other things, the team serves to: integrate waiver policies, review drafted policies and other reports related to HCBS waivers that assure consistency with quality standards; share information regarding best practices; design, generate, and review comparative performance reports; collaborate on joint policy for rules, issues, policies for Support Coordination, Direct Service Providers, and Critical Incident Reporting.

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.:*

The Medicaid data contractor tracks data on plans of care, such as date the initial plan is submitted and approved, date the annual POC is approved, date the POC is received by the regional office, etc.; tracks support coordination, provider services, waiver slots both occupied and vacant, tracks information on time lines, offerings of waiver slots and linkages to support coordination agencies, tracks Waiver certification process; provides prior authorization functions; maintains the Request for Services Registry; issues freedom of

choice forms to the participant/family members to select a Support Coordination Agency, collects data from providers, provides notification to providers.

The fiscal/employer agent ensures that participants prior authorized service limits for self-directed services are not exceeded; executes provider agreements on behalf of the Medicaid agency, and processes employer-related payroll and necessary taxes on behalf of Self-Direction participants.

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:

BHSF is responsible for oversight and assessing the performance of the Medicaid Data Contractor.

BHSF and OCDD execute a contract with the Fiscal Agent (FMS) for the performance of administrative functions associated with the provision of services under the Self-Direction Program as specified in Appendix E-1-i-iii. BHSF and OCDD utilize contract monitors to assure that the deliverables of the contract are achieved. The Fiscal Agent will submit various reports, documentation and data to the BHSF and OCDD contract monitors for the purpose of monitoring and oversight of the contracted functions.

The Fiscal Agent will provide (every two weeks) BHSF and OCDD with billing reports indicating appropriate expenditures for participant directed services. Both BHSF and OCDD participate in ongoing meetings related to any issues as well as written status reports on contractual objectives.

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:

The Medicaid Contract Monitor for the Medicaid Data Contractor reviews a report listing the activities and deliverables for the previous month. This report includes support coordination linkage, period of time between linkage and service delivery, number of new and closed support coordination linkages and summary statistics. The previous month's billing information is also included in the report so the report and invoice are linked together.

In addition, the data contractor submits a breakdown of staff resources allocated to the contract. WCS staff, including the contract monitor, meet twice monthly with contractor to review performance. The data contractor also submits data files quarterly which are reviewed and archived by the contract monitor. The types of data files submitted by the data contractor to the contract monitor include: waiver expenditures managed against approved limits, waiver expenditures managed against approved levels, and prior authorization of waiver services. LOC timeliness, and POC timeliness.

Any request for ad hoc report generation or any change to the computer application that is above the standard services delivered by the contractor must be approved by the contract monitor. In the past, the majority of these requests are for ad hoc reports.

Waiver Assistance and Compliance staff meet bi-weekly to review contract work, issues, problems and deliverables.

The fiscal/employer agent is required to submit monthly reports to BHSF and OCDD for review and to monitor fiscal management activities. BHSF and OCDD perform on-going monitoring of the fiscal/employer agent's claims payment activities, billing history, and adherence to the terms of the contract. OCDD provides BHSF with any data, complaints, or other information obtained from any source regarding the fiscal/employer agent's performance.

BHSF requires the fiscal/employer agent to 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. In addition, BHSF and OCDD utilize participant-satisfaction survey data gathered by the FMS and complaint data to assess the fiscal/employer agent's performance. If any problems are identified, BHSF and OCDD will require a corrective action plan from the fiscal/employer agent and will monitor implementation.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*): In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

For each performance measure 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.1. Number and percentage of policies and provider notices that have been approved by WCS prior to implementation by the operating agency. Percentage = Number of policies and provider notices approved by WCS prior to implementation by the operating agency / Total number of policies and provider notices implemented.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Program logs

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

A.a.i.2. Number and percentage of agreed upon waiver assurance trend and data reports that were submitted timely, as defined by contract/other agreement, by the operating agency/contractor, separated by entity. Percentage = Number of trend and data reports submitted timely by the operating agency and data contractor/ Total number of agreed upon waiver assurance trend and data 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

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

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

Performance Measure:

A.a.i.3. Number and percentage of waiver offers that were appropriately made, according to policy, to applicants on the Request for Services Registry (RFSR). Percentage = Number of appropriately made offers to applicants on the RFSR /Total number of waiver offers made.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

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

	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Random look-behind review of at least 5 offers per quarter
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

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

Performance Measure:

A.a.i.4. Number and percentage of level of care/plan of care/critical incident remediation activities occurring in a timely fashion, defined as 30 days or less, separated by report type. Percentage = number of issues remediated timely / total number of issues identified as requiring remediation.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

	<input type="checkbox"/> Other Specify: 	
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Data Aggregation and Analysis:

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

Performance Measure:

A.a.i.5. Number and percentage of waiver participants whose services did not exceed the service limits authorized on their plan of care. Percentage = number of plans for which services did not exceed the service limits specified in the approved plan of care / total number of plans.

Data Source (Select one):

Other

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

A.a.i.6. Number and percentage of self-direction participants who report satisfaction with the performance of the fiscal agent. Percentage = number of participants who report satisfaction with the performance of the fiscal agent / total number of participants who responded to the survey.

Data Source (Select one):

Participant/family observation/opinion

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

A.a.i.7. Number and percentage of complaints addressed by the fiscal/employer agent within 10 business days. Percentage= Number of complaints addressed by the fiscal/employer agent within 10 business days / Total number of complaints received.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

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

Performance Measure:

A.a.i.8. Number and percentage of reports in which the waiver recipient count was not exceeded, as specified in the waiver application. Percentage= Number of reports in which the waiver recipient count was not exceeded / Total number of reports reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

372 report

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

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

Performance Measure:

A.a.i.9. Number and percentage of plans of care in which prior authorizations that were issued correctly, according to policy. Percentage = Number of prior authorizations that were issued correctly / Total number of prior authorizations reviewed in the sample.

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input type="checkbox"/> Other Specify: Medicaid data contractor	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Random review of at least 10 participants plan of care per quarter
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Specify: Medicaid data contractor	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

Performance Measure:

A.a.i.10. Number and percentage of recipients residing in provider owned or controlled settings in which the HCB character is maintained. Percentage = Number of recipients residing in a provider owned or controlled setting in which the HCB character is maintained / Total number of recipients residing in provider owned or controlled settings.

Data Source (Select one):

Other

If 'Other' is selected, specify:

CMIS

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

Data Aggregation and Analysis:

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

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

- 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.
A.a.i.9 is used in conjunction with indicator A.a.i.5, which includes a 100% review.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

A variety of mechanisms are employed by WCS to ensure all issues with the operating agency/contractor's performance are remediated:

1. WCS meets with contractors and operating agency staff on an as needed basis but no less than quarterly to discuss delegated functions, pending issues, and remediation plans. Individual issues requiring remediation will be referred back to the operating agency and/or contractor for correction. WCS will monitor to ensure remediation activities are completed to address any identified areas of non-compliance within 30 days of notification. Systemic issues requiring remediation will be identified and discussed at the Cross Waiver (which includes staff from WCS, OAAS, and OCDD) Review Team Committee meetings. A plan for remediation and person responsible will be developed for each item identified. Remediation strategies and progress towards correction will be reviewed and documented at the next scheduled meeting.

2. WCS, the Medicaid Director or Deputy Director, the OCDD' Assistant Secretary, and other pertinent staff meet on at least a quarterly basis to discuss any pending issues and remediation plans.

3. Memorandums are sent from BHSF to OCDD to ensure all necessary leadership is informed of the support actions needed to correct problems or make improvements.

ii. Remediation Data Aggregation

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

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

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 SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input checked="" type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism	0		<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability	0		<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability	0		<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

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

- ☒ Not applicable. There is no maximum age limit
- ☐ The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

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 service 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 Individual Cost Limit is 100% of the cost of care for the highest acuity level for persons in private ICFs/DD. This is evidenced by figures included in Appendix J-1 where factor G costs in column 5 (representing an average of all ICFs/DD institutional costs) exceed estimates for the annual average costs for ROW participants in factor D column 2 (which are based on the highest acuity levels for persons in private ICFs/DD). All comparisons are based on utilization data for target groups similar to those who will be participating in the ROW.

Factor D costs are only community costs for ROW participants. There are no institutional costs reflected in factor D. Louisiana uses scores from the Inventory for Client and Agency Planning (ICAP) assessment to determine reimbursement rates specific to four acuity levels of need (intermittent, limited, extensive, pervasive) identified in the ICAP. Those same acuity levels and rates are applied to ROW participants living in the community. This assures fairness and cost effectiveness since the individual cost limit for ROW participants does not exceed 100% of the cost of care for the highest acuity level for persons in private ICFs/DD.

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: _____

The Individual Cost Limit is 100% of the cost of care for the highest acuity level for persons in private ICFs/DD.

Appendix B: Participant Access and Eligibility

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

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

OCDD will use the following procedures to determine in advance that each individual entering the ROW will have his/her health and safety needs met within the ROW's established Individual Cost Limit

- A person-centered planning process guided by the support coordinator and a team involving residential, vocational, medical, behavioral and other professional service providers along with the individual and his family culminates in a Plan of Care. This planning process selects and prioritizes each service needed by the individual into objectives and documents their frequency, duration, location, time, method of delivery and cost, consistent with the participant's strengths, health status, choices, goals and desired outcomes. The support coordinator also arranges any additional assessments or professional evaluations needed to develop strategies for successful implementation of this plan and considers all available natural and community resources, SSI funding and food/housing subsidies available.

- o The planning process also considers each individual's daily schedule, need for assistance with activities of daily living, capacity for functioning independently and health status in determining whether more cost-effective or shared services may be used. Examples may include shared direct support staff, shared nursing services and the use of technological devices for emergency situations (e.g. personal emergency response systems) in lieu of direct support staff.

- o Each Plan of Care contains a detailed budget sheet which outlines the cost of each service multiplied by the total number of service units and frequency required for an individual within his/her overall budget amount and will allow for unanticipated increases in service needs due to emergency or crisis situations.

- The OCDD Regional Waiver Supports and Services Offices or Human Services Authorities or Districts are responsible for approving each participant's Plan of Care relative to his/her health and safety needs being assured within the array of services selected and each provider's ability to deliver those services. This is done prior to service delivery and through communication with the support coordinator so that rejected Plans of Care may be revised with technical assistance from the OCDD Regional Waiver Supports and Services Offices or Human Services Authorities or Districts.

- Each residential and vocational provider must document completion of their own service plans which mirror the Plan of Care and outlines specifics on how services will be delivered in their settings. The support coordinator is responsible for reviewing and assuring that these plans correctly implement the objectives within the approved Plan of Care.

- OCDD State Office staff are available to provide technical assistance to support coordinators or OCDD Regional Waiver Supports and Services Offices or Human Services Authorities or Districts when difficulties arise in overcoming barriers to successful service planning or when health and safety factors cannot be overcome at the local level or when assistance is needed to mitigate risk factors or utilization issues.

If an individual is denied admission to the waiver they are provided with written notification of the denial and the opportunity to request a fair hearing as described below:

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

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

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

During the initial assessment process, the Support Coordinator will give a participant and his/her legal representatives an OCDD information sheet entitled "Rights and Responsibilities for Applicants/Participants of a Home and Community Based Waiver" which includes information on how to file a complaint, grievance, or appeal with the Louisiana Department of Health and Hospitals. A copy of this information sheet is kept in the participant's record at the Support Coordination agency's physical location of business. In addition, the Plan of Care contains a section that addresses the right to a fair hearing within ten days, and how to request a fair hearing, if the participant and his/her legal representatives disagree with any decision rendered regarding approval of the Plan of Care. Dated signatures of the participant, his/her legal representatives, and a witness are required on this section. Copies of the Plan of Care, including this section are kept in the appropriate OCDD Regional Waiver Supports and Services Offices or Human Services Authorities or Districts and the Support Coordination agency's physical location of business.

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

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

In accordance with 42CFR 431.206, 210 and 211, participants receiving waiver services, and their legal representatives are sent a certified letter with return receipt to ensure the participant receives it by the appropriate OCDD Regional Waiver Supports and Services Offices or Human Services Authorities or Districts providing ten days advance and adequate notification of any proposed denial, reduction, or

termination of waiver services. Included in the letter are instructions for requesting a fair hearing, and notification that an oral or written request must be made within ten days of receipt of a proposed adverse action by the OCDD Regional Waiver Supports and Services Offices or Human Services Authorities or Districts in order for current waiver services to remain in place during the appeal process. If the appeal request is not made within ten days, but is made within thirty days, all Medicaid waiver services are discontinued on the eleventh day; services that are continued until the final decision is rendered are not billable under the Medicaid waiver. If the final decision of the Administrative Law Judge is favorable to the appellant, services are re-implemented from the date of the final decision. An appeal hearing is not granted if the appeal request is made later than thirty days following receipt of a proposed adverse action sent by the OCDD Regional Waiver Supports and Services Offices or Human Services Authorities or Districts. Once a request for an appeal is received, the OCDD Regional Waiver Supports and Services Offices or Human Services Authorities or Districts must submit the request to the Division of Administrative Law - Health and Hospitals Section no later than seven calendar days after receipt. A copy of the letter and the response/request is kept in the participant's record at the appropriate OCDD Regional Waiver Supports and Services Offices or Human Services Authorities or Districts.

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

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

Anyone requesting an appeal has the right to withdraw the appeal request at any time prior to the hearing. The appellant may contact the Division of Administrative Law - Health and Hospitals Section directly, or may request withdrawal through the OCDD Regional Waiver Supports and Services Offices or Human Services Authorities or Districts. Requests for withdrawal are kept in the participant's record at the appropriate OCDD Regional Waiver Supports and Services Offices or Human Services Authorities or Districts.

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

The participant's Plan of Care is reviewed quarterly or more frequently as needed, to ensure that services continue to meet the participant's health and safety needs. The Support Coordinator will review and ensure that all other services provided through the waiver are being provided in a cost effective manner.

A reassessment of the participant's ICAP level will be conducted to determine the most appropriate support level. If it is determined that the ROW can no longer meet the participant's health and safety and support the participant, the participant is referred to another waiver that can accommodate the participant's needs.

All Medicaid services options will be explored, including ICF/DD placement.

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	

Waiver Year	Unduplicated Number of Participants
	225
Year 2	325
Year 3	425
Year 4	525
Year 5	625

- 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	220
Year 2	320
Year 3	408
Year 4	502
Year 5	590

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
Adults and children in nursing facilities who wish to transition to HCBS based on their Request for Services Registry protected date
Children (birth through 18) in nursing facilities requiring high-need rates who wish to transition to HCBS who participate in the MFP
Participants with OCDD Statement of Approval and who formerly received OAAS Community Choice Wavier (CCW) and or Adult Day Health Care (ADHC) services transitioning to the ROW
Persons who need HCBS due to a crisis situation
Persons Transitioning from Supports and Services Centers to HCBS
Persons voluntarily transitioning from ICFs/DD to HCBS based on their RSFR protected date
Persons voluntarily transitioning from ICFs/DD to HCBS through conversion

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):

Adults and children in nursing facilities who wish to transition to HCBS based on their Request for Services Registry protected date

Purpose (describe):

Provide ROW opportunity to persons who are qualified for both DD services and for a nursing facility due to their complex medical needs and who are on the Request for Services Registry. The ROW will provide a waiver opportunity for transition into the community.

Describe how the amount of reserved capacity was determined:

The amount of the reserved capacity is based on the number of adults and children residing in nursing homes who meet the ICF/DD level of care based on data obtained from the Medicaid Program and who have requested home and community based services.

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

Waiver Year	Capacity Reserved
Year 1	15
Year 2	20
Year 3	25
Year 4	30
Year 5	40

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):

Children (birth through 18) in nursing facilities requiring high-need rates who wish to transition to HCBS who participate in the MFP

Purpose (describe):

Provide ROW opportunities to children who reside in nursing facilities who are birth through age 18 and are qualified for both DD services and for a nursing facility due to multiple and complex medical needs requiring higher-need nursing facility rates and participate in the MFP. The ROW will provide a waiver opportunity for transition into the community.

Describe how the amount of reserved capacity was determined:

The amount of the reserved capacity is based on the number of children identified who reside in nursing facilities and who qualify for the ICF/DD level of care.

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

Waiver Year	Capacity Reserved
Year 1	20
Year 2	24
Year 3	28
Year 4	32
Year 5	36

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):

Participants with OCDD Statement of Approval and who formerly received OAAS Community Choice Wavier (CCW) and or Adult Day Health Care (ADHC) services transitioning to the ROW

Purpose (describe):