Agency

Provider Type:
Permanent Supportive Housing Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Community Psychiatric and Support Team
Other Standard *(specify):*
Permanent Supportive Housing (PSH) Agency under contract and enrolled with the Department of Health and Hospitals Statewide Management Organization for Behavioral Health Services plus either:
1. meeting requirements for completion of training program as verified by the PSH director; or
2. have at least one year of completion of housing support team experience in the PSH program as verified by the PSH director.

Verification of Provider Qualifications
Entity Responsible for Verification:
OAAS, the program office housing the PSH Director
Frequency of Verification:
Initial and annual thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Housing Stabilization Transition Service

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Housing Stabilization Transition Service enables participants who are transitioning into a PSH unit, including those transitioning from institutions, to secure their own housing. The service is provided while the participant is in an institution and preparing to exit the institution using the waiver. The service includes the following components:
1. Conduct a housing assessment identifying the participant's preferences related to housing (type, location, living alone or with someone else, accommodations needed, other important preferences) and needs for support to maintain housing (including access to, meeting terms of lease, and eviction prevention), budgeting for housing/living expenses, obtaining/accessing sources of income necessary for rent, home management, establishing credit and understanding and meeting obligations of tenancy as defined in lease terms.
2. Assist participant to view and secure housing as needed. This may include arranging or providing transportation. Assist

participant to secure supporting documents/records, completing/submitting applications, securing deposits, locate furnishings.

3. Develop an individualized housing stabilization service provider plan based upon the housing assessment that includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies where other provider(s) or services may be required to meet the goal.
4. Participate in the development of the plan of care, incorporating elements of the housing stabilization service provider plan.
5. Look for alternatives to housing if permanent supportive housing is unavailable to support completion of transition.

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

Available only to participants who:

- Are residing in a State of Louisiana Permanent Supportive Housing unit or
- Are linked for the State of Louisiana Permanent Supportive Housing selection process

Limited to:

- No more than 165 combined units of this service and the Housing Stabilization service (units can only be exceeded with written approval from OCDD)

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Permanent Supportive Housing Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Housing Stabilization Transition Service

Provider Category:

Agency ☐

Provider Type:

Permanent Supportive Housing Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Community Psychiatric and Support Team

Other Standard *(specify):*

Permanent Supportive Housing (PSH) Agency under contract and enrolled with the Department of Health and Hospitals Statewide Management Organization for Behavioral Health Services plus either:

1. meeting requirements for completion of training program as verified by the PSH director; or
2. have at least one year of completion of housing support team experience in the PSH program as verified by the PSH director.

Verification of Provider Qualifications

Entity Responsible for Verification:

OAAS, the program office housing the PSH Director

Frequency of Verification:

Initial and annual thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Nursing

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Nursing services are provided by a registered nurse, or a licensed practical nurse under the supervision of a registered nurse, licensed to practice in the State of Louisiana.

Nursing services must be included in the participant's Plan of Care and have the following:

- Physician's order,
- Physician's letter of medical necessity,
- 90-L,
- Form 485,
- Individual nursing service plan,
- Summary of medical history, and
- Skilled nursing checklist.

The participant's nurse must submit updates every sixty (60) days and include any changes to the participant's needs and/or physician's orders.

Consultations include assessments, health related training/education for participant and the participant's caregivers, and healthcare needs related to prevention and primary care activities.

Assessments services are offered on an individualized basis only and must be performed by a Registered Nurse.

Health related training and education service is the only nursing procedure which can be provided to more than one participant simultaneously.

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

Nursing services are secondary to EPSDT services for participants under the age of 21.

Participants under the age of 21 have access to nursing services (home health and extended care) under Medicaid State Plan. Adults have access only to Home Health nursing services under Medicaid State Plan. Participants must access and exhaust all available Medicaid State Plan services prior to accessing ROW Nursing services.

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

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

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

- **Legally Responsible Person**
- **Relative**

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Shared Living

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Home Health Agency License
LA RS Title 40:2016-2016.40
Certificate *(specify):*

Other Standard *(specify):*
Nurses must have 1 year experience serving persons with developmental disabilities. Experience may include any of the following:

- Full-time experience gained in advanced and accredited training programs, (i.e., masters or residency level training programs) which includes treatment services to persons with a developmental disability;
- Paid, full-time nursing experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);
- Paid, full-time nursing experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or
- Paid, full-time nursing experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

Note: 2 years of part-time experience (minimum of 20 hours per week) may be substituted for 1 year of full-time experience.

The following activities do not qualify for the required experience:

- Volunteer nursing experience; or
- Experience gained by caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Health and Hospitals (Health Standards Section)
Frequency of Verification:
Initially, annually and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing

Provider Category:
Agency
Provider Type:
Shared Living
Provider Qualifications
License *(specify):*
Providers must be licensed by the Louisiana Department of Health and Hospitals as a home and community-based services provider and meet the module requirements for Supervised Independent Living-Conversion.
LAC 48:1.Chapter 50
Certificate *(specify):*

Other Standard *(specify):*
Nurses must have 1 year experience serving persons with developmental disabilities. Experience may include any of the following:

- Full-time experience gained in advanced and accredited training programs, (i.e., masters or residency level training programs) which includes treatment services to persons with a developmental disability;
- Paid, full-time nursing experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);
- Paid, full-time nursing experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or
- Paid, full-time nursing experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

Note: 2 years of part-time experience (minimum of 20 hours per week) may be substituted for 1 year of full-time experience.

The following activities do not qualify for the required experience:

- Volunteer nursing experience; or
- Experience gained by caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Hospitals (Health Standards Section)
Frequency of Verification:
Initially, annually and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
One-Time Transitional Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
One Time Transitional Services are non-reoccurring set-up expenses to assist a participant who is moving from an institutional setting to their own home.

One-Time Transitional Services may be accessed for the following:

- Non-refundable security deposit;
- Utility deposits;
- Bedroom furniture;
- Living room furniture;
- Table and chairs;
- Window blinds;
- Kitchen items (i.e., food preparation items, eating utensils, etc);
- Moving expenses; and
- Health and safety assurances (i.e., pest eradication, one-time cleaning prior to occupancy, etc.).

The participant's support coordinator assists in accessing funds and making arrangements in preparation for moving into the residence.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
There is a one-time,life time maximum service of $3,000 per participant. Service expenditures will be prior authorized and tracked by the prior authorization contractor.

One Time Transitional Services may not be used to pay for furnishings or setting up living arrangements that are owned or leased by a waiver provider.

Security deposits are not to include rental payments.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transition Support Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: One-Time Transitional Services

Provider Category:
Agency
Provider Type:
Transition Support Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
BHSF (Medicaid) Provider Enrollment Agreement
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Health and Hospitals (Health Standards Section)
Frequency of Verification:
Initially, annually and as necessary

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition *(Scope):*

Personal Emergency Response System service is an electronic device connected to the participant's phone which enables him/her to secure help in an emergency. The service also includes an option in which the participant would wear a portable "help" button. The device is programmed to emit a signal to the Personal Emergency Response System Response Center where trained professionals respond to the participant's emergency situation.

Personal Emergency Response System service is most appropriate for participants who are able to identify when they are in an emergency situation and are then able to activate the system requesting assistance. This service would be beneficial to participants who are unable to summon assistance by dialing 911 or other emergency services available to the general public.

Installation, participant training, a monthly monitoring fee, and the cost of maintenance are included in the Personal Emergency Response System service.

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

Not available to participants who receive 24 hour direct care supports.

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

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

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

- **Legally Responsible Person**
- **Relative**
- **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Emergency Response System

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:
Agency
Provider Type:
Personal Emergency Response System
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers must comply with all applicable federal, state, county (parish) and local laws and regulations and meet manufacturer's specifications, response requirements, maintenance records, and enrollee education. The provider's Response Center shall be staffed by trained professionals.

Qualifications for staff working in the response centers: Certified "Emergency Medical Dispatcher"

The term Emergency Medical Dispatcher is a certification level and a professional designation, certified through the National Academies of Emergency Dispatch. The Emergency Medical Dispatcher is a professional telecommunicator who will fill a number of critical functions, including the identification of basic call information, including the location and telephone number of the caller, the location of the patient, the general nature of the problem, and any special circumstances. The Emergency Medical Dispatcher will then use an approved set of protocols to provide first aid and pre-arrival assistance and instructions by voice to the subscriber and/or bystander prior to the arrival of Emergency Medical Services.

Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid Fiscal Intermediary (Molina or the current contractor)
Frequency of Verification:
Initially, annually and as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Professional Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Service Definition *(Scope):*

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

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

Professional services include nutritional services, speech therapy, occupational therapy, physical therapy, social work, and psychological services which assist the participant, unpaid caregivers, and/or paid caregivers in carrying out the participant's approved plan and which are necessary to improve the participant's independence and inclusion in his/her community.

Professional Services are direct services to participants and are based on the participant's need. The participant must be present in order for the professional to bill for services. All services are to be included in the participant's Plan of Care. The specific service provided to a participant must be within the professional's area of specialty and licensing.

Professional Services can include:

- Assistance in increasing independence, participation and productivity in the participant's home, work and/or community environments
- Assessments and/or re-assessments specific to the protocols of the area of specialty with the goal of identifying status and developing recommendations, treatment, and follow-up
- Providing information to the participant, family, caregivers, along with other support team members to assist in planning, developing, and implementing a participant's Plan of Care
- Providing consultative services and recommendations as the need arises
- Providing training to the participant, family, and caregivers with the goal of increased skill acquisition and proficiency.
- Providing therapy to the participant necessary to the development of critical skills
- Intervening in a crisis situation with the goal of stabilizing and addressing issues related to the cause(s) of the crisis; activities may include development of support plan(s), training, documentation strategies, counseling, on-call supports; back-up crisis supports, on-going monitoring and intervention
- Providing training and counseling services for natural supports and caregivers in a home setting with the goal of developing and maintaining healthy, stable relationships.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Private Insurance must be billed and exhausted prior to accessing waiver funds.

Children must access and exhaust services through EPSDT prior to accessing waiver funds.

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

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

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

- **Legally Responsible Person**
- **Relative**
- **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Speech Therapist
Individual	Physical Therapist
Individual	Occupational Therapist
Agency	Rehabilitation Center
Agency	Home Health Agency
Individual	Social Worker
Individual	Psychologist
Individual	Registered Dietician
Agency	Substitute Family Care
Agency	Federally Qualified Health Center
Agency	Shared Living

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Individual

Provider Type:
Speech Therapist

Provider Qualifications

License *(specify):*
Speech Therapist License
LA RS 37:2650-2666

Certificate *(specify):*

Other Standard *(specify):*
Have a minimum of 1 year experience delivering services to persons with developmental disabilities specific to speech therapy. Experience may include any of the following:

- Full-time experience gained in advanced and accredited training programs, (i.e. masters or residency level training programs) which include services for persons with a developmental disability;
- Paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);
- Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or
- Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

Note: 2 years of part-time experience (minimum of 20 hours per week) may be substituted for 1 year of full-time experience.

The following activities do not qualify for the required experience:

- Volunteer professional experience; or
- Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana Board of Examiners for Speech Language Pathology and Audiology

Frequency of Verification:
Initially, annually, and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Individual

Provider Type:
Physical Therapist

Provider Qualifications

License *(specify):*
Physical Therapist License
LA RS 37:2401-2421

Certificate *(specify):*

Other Standard *(specify):*
Have a minimum of 1 year experience delivering services to persons with developmental disabilities specific to physical therapy. Experience may include any of the following:

- Full-time experience gained in advanced and accredited training programs, (i.e., masters or residency level training programs) which includes treatment services for persons with a developmental disability;

- Paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);
- Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or
- Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

Note: 2 years of part-time experience (minimum of 20 hours per week) may be substituted for 1 year of full-time experience.

The following activities do not qualify for the required experience:
- Volunteer professional experience; or
- Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana Physical Therapy Board

Frequency of Verification:
Initially, annually and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Individual

Provider Type:
Occupational Therapist

Provider Qualifications

License *(specify):*
Occupational Therapist License
LA RS 37:3001-3014

Certificate *(specify):*

Other Standard *(specify):*
Have a minimum of 1 year experience delivering services to persons with developmental disabilities specific to occupational therapy. Experience may include any of the following:
- Full-time experience gained in advanced and accredited training programs, (i.e., masters or residency level training programs) which includes services for persons with a developmental disability;
- Paid, full-time professional experience in specialized service/treatment settings for persons with developmental disability (i.e., intermediate care facilities for persons with a developmental disability);
- Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or
- Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

Note: 2 years of part-time experience (minimum of 20 hours per week) may be substituted for 1 year of full-time experience.

The following activities do not qualify for the required experience:
- Volunteer professional experience; or
- Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana State Board of Medical Examiners

Frequency of Verification:
Initially, annually, or as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Agency
Provider Type:
Rehabilitation Center
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Medicare Certification Letter confirming enrollment as either a Rehabilitation Agency or a Comprehensive Outpatient Rehabilitation Facility (CORF)
Other Standard *(specify):*
Agency staff providing professional services to ROW participants must:

Have a minimum of 1 year experience delivering services to persons with developmental disabilities specific to psychology. Experience may include any of the following:

- Full-time experience gained in advanced and accredited training programs, (i.e., masters or residency level training programs) which includes treatment services for persons with a developmental disability;
- Paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);
- Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or
- Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

Note: 2 years of part-time experience (minimum of 20 hours per week) may be substituted for 1 year of full-time experience.

The following activities do not qualify for the required experience:

- Volunteer professional experience; or
- Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Health and Hospitals (Health Standards Section)
Frequency of Verification:
Initially, annually and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Home Health Agency License
LA RS 40.2116.31-2116.40
Certificate *(specify):*

Other Standard *(specify):*
Agency staff providing professional services to ROW participants must:

Have a minimum of 1 year experience delivering services to persons with developmental disabilities specific to psychology. Experience may include any of the following:

- Full-time experience gained in advanced and accredited training programs, (i.e., masters or residency level training programs) which includes treatment services for persons with a developmental disability;
- Paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);
- Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or
- Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

Note: 2 years of part-time experience (minimum of 20 hours per week) may be substituted for 1 year of full-time experience.

The following activities do not qualify for the required experience:

- Volunteer professional experience; or
- Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Hospitals (Health Standards Section)
Frequency of Verification:
Initially, annually and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Individual
Provider Type:
Social Worker
Provider Qualifications

License *(specify):*
Social Work License
LA RS 37:2701-2723
Certificate *(specify):*

Other Standard *(specify):*
Have a minimum of 1 year experience delivering services to persons with developmental disabilities specific to social work. Experience may include any of the following:

- Full-time experience gained in advanced and accredited training programs, (i.e., masters or residency level training programs) which includes treatment services for persons with developmental disability;
- Paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);
- Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or
- Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

Note: 2 years of part-time experience (minimum of 20 hours per week) may be substituted for 1 year of full-time experience.

The following activities do not qualify for the required experience:

- Volunteer professional experience; or
- Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana State Board of Social Work Examiners
Frequency of Verification:
Initially, annually and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Individual

Provider Type:
Psychologist

Provider Qualifications

License *(specify):*
Psychology License
LA RS 37:2356

Certificate *(specify):*

Other Standard *(specify):*
Have a minimum of 1 year experience delivering services to persons with developmental disabilities specific to psychology. Experience may include any of the following:

- Full-time experience gained in advanced and accredited training programs, (i.e., masters or residency level training programs) which includes treatment services for persons with a developmental disability;
- Paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);
- Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or
- Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

Note: 2 years of part-time experience (minimum of 20 hours per week) may be substituted for 1 year of full-time experience.

The following activities do not qualify for the required experience:

- Volunteer professional experience; or
- Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana State Board of Examiners of Psychologists

Frequency of Verification:
Initially, every two years, and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Individual

Provider Type:
Registered Dietician

Provider Qualifications

License *(specify):*
Dietician/Nutritionist License
LA RS 37:3086

Certificate *(specify):*

Other Standard *(specify):*
Have a minimum of 1 year experience delivering services to persons with developmental disabilities specific to nutrition/dietary supports. Experience may include any of the following:

- Full-time experience gained in advanced and accredited training programs, (i.e., masters or residency level training programs) which includes treatment services for persons with a developmental disability;

- Paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);
- Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or
- Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

Note: 2 years of part-time experience (minimum of 20 hours per week) may be substituted for 1 year of full-time experience.

The following activities do not qualify for the required experience:
- Volunteer professional experience; or
- Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana Board of Examiners in Dietetics and Nutrition

Frequency of Verification:
Initially, annually and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Agency

Provider Type:
Substitute Family Care

Provider Qualifications

License *(specify):*
Children:
Class A Child Placing Agency
Act 286 of 1985, LAC Title 48 Chapter 41

Adults:
Providers must be licensed by the Louisiana Department of Health and Hospitals as a home and community-based services provider and meet the module requirements for Substitute Family Care.
LAC 48:1.Chapter 50

Certificate *(specify):*

Other Standard *(specify):*
Agency staff providing professional services to ROW participants must:

Have a minimum of 1 year experience delivering services to persons with developmental disabilities specific to psychology. Experience may include any of the following:
- Full-time experience gained in advanced and accredited training programs, (i.e., masters or residency level training programs) which includes treatment services for persons with a developmental disability;
- Paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);
- Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or
- Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

Note: 2 years of part-time experience (minimum of 20 hours per week) may be substituted for 1 year of full-time experience.

The following activities do not qualify for the required experience:
- Volunteer professional experience; or
- Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Family and Child Services (Bureau of Licensing)

Department of Health and Hospitals (Health Standards Section)
Frequency of Verification:
Initially, annually and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Agency
Provider Type:
Federally Qualified Health Center
Provider Qualifications
License *(specify):*

Certificate *(specify):*
HRSA Grant Award letter
or
CLIA Certificate (if applicable)
Other Standard *(specify):*
Agency staff providing professional services to ROW participants must:

Have a minimum of 1 year experience delivering services to persons with developmental disabilities specific to psychology. Experience may include any of the following:
- Full-time experience gained in advanced and accredited training programs, (i.e., masters or residency level training programs) which includes treatment services for persons with a developmental disability;
- Paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);
- Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or
- Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

Note: 2 years of part-time experience (minimum of 20 hours per week) may be substituted for 1 year of full-time experience.

The following activities do not qualify for the required experience:
- Volunteer professional experience; or
- Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Health and Hospitals (Health Standards Section)
Frequency of Verification:
Initally, annually, and as necessary.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Agency
Provider Type:
Shared Living
Provider Qualifications
License *(specify):*
Providers must be licensed by the Louisiana Department of Health and Hospitals as a home and community-based services provider and meet the module requirements for Supervised Independent Living and/or Supervised Independent

Living-Conversion.
LAC 48:1.Chapter 50
Certificate *(specify):*

Other Standard *(specify):*
Agency staff providing professional services to ROW participants must:

Have a minimum of 1 year experience delivering services to persons with developmental disabilities specific to psychology. Experience may include any of the following:

- Full-time experience gained in advanced and accredited training programs, (i.e., masters or residency level training programs) which includes treatment services for persons with a developmental disability;
- Paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);
- Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or
- Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

Note: 2 years of part-time experience (minimum of 20 hours per week) may be substituted for 1 year of full-time experience.

The following activities do not qualify for the required experience:

- Volunteer professional experience; or
- Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Hospitals (Health Standards Section)
Frequency of Verification:
Initially, annually and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

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

Service Title:
Transportation - Community Access

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Transportation-Community Access services are provided to assist the participant in becoming involved in his/her community. The service encourages and fosters the developmental of meaningful relationships in the community which reflects the participant's choice and values.

This service provides the participant with a means of access to community activities and resources. The goal is to increase the participant's independence, productivity, and community inclusion. Transportation-Community Access service is to be included in the participant's Plan of Care and the participant must be present to be billed.

Prior to accessing Transportation-Community Access service, the participant is to utilize free transportation provided by family, friends, and community agencies. When appropriate, the participant should access public transportation or the most cost-effective method of transportation prior to accessing Transportation-Community Access service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limited to no more than three roundtrips per day.

Transportation - Community Access services may not be billed for on the same day at the same time as Community Living Supports.

This service shall not replace:
- Transportation services to medically necessary services under the State Plan;
- Transportation services provided as a means to get to and from school.
- Transportation services to or from Day Habilitation, Prevocational Services, or Supported Employment Services

Transportation-Community Access is not available to participants receiving:
- Companion Care
- Host Home
- Shared Living

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	NEMT (Friends and Family Transportation)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation - Community Access

Provider Category:
Individual

Provider Type:
NEMT (Friends and Family Transportation)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Maintain compliance with:
- State minimum automobile liability insurance coverage,
- Possess a current state inspection sticker, and
- Possess a current valid driver's license.

May provide transport for up to three identified participants

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Hospitals (Bureau of Health Services Financing)

Frequency of Verification:

Initially for enrollment of providers

Appendix C: Participant Services

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

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

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

Check each that applies:

- **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- **As an administrative activity.** *Complete item C-1-c.*

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

Appendix C: Participant Services

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

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

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

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

In accordance with Home and Community Based Services Provider Licensing Standards-LAC 48:1, Chapter 50, 1500-1532 and Louisiana R.S. 40:1300.52, criminal history/background checks are conducted on all unlicensed persons. The background checks are not conducted by the operating agency, but are done by the Louisiana State Police (LSP) or their authorized agent. A state wide check is performed.

- The Louisiana State Police (LSP), or the LSP designee companies they recognize as competent, perform the actual criminal history/background checks and security check on the individual.
- New employee background checks/security checks are reviewed by Health Standards Section during licensing and monitoring reviews.

All persons who provide direct waiver services for children and adults who have disabilities are monitored by Health Standards Section for compliance with applicable laws as follows:

- Children's Code Title VI, Chapter 1, Article 601–606 and Title VI, Chapter 5, Article 609-611;
- LA. R.S. 14:403, abuse of children;
- LA R.S. 14:403.2 XI-B; abuse and neglect of adults (includes disabled adults); and
- LA R.S. 40:1300.53, "Criminal History Checks on Non-licensed Persons and Licensed Ambulance Personnel" The LA R.S. 40:1300.52 statute was amended by Act 816 of the 2006 Regular Legislative Session which required the criminal background check to now include a security check. The security check will search the national sex offender public registry. All direct support provider agencies are encouraged to become familiar with, and have on hand, the above mentioned statutes as a reference when hiring.
- ACT 816 finalized in 6/30/2006 added security checks for identification of sex offenders & authorized release of potential employees results to the employer.
- ACT 35 finalized in 6/15/2009 prohibited providers hiring any staff with a conviction for a list of 17 crimes (non- waivable

• Home & Community-Based Services Providers Minimum Licensing Standards (LAC 48: I Chapter 50) June 20, 2011 Emergency Rule with a final Rule published on January 20, 2012 Louisiana Register Vol. 38. No.1 January 20, 2012. This final HCBS Licensing rule includes:

o Criminal background checks and sex offender checks to be done on the owners and continued for all other non-licensed employees who provide personal care or other services and supports to persons with disabilities or the elderly.

o Includes providers being prohibited in hiring any staff without a criminal background and security check and cannot hire any staff with the specific convictions that are non- waivable (17 specific non-waivable convictions) and;

o Includes employee is not to work with client until results of criminal background check and security check is back and eligible for employment.

• Health Standards Section State Survey Agency conducts Investigations for Complaints and Monitoring for licensing surveys and reviews the staff's criminal background/security checks as well as the criminal background/security checks on the owners.

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

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

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

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

The state maintains a registry that includes the names of all direct service workers who have had findings of abuse, neglect or misappropriation of property placed against them. Providers are required to check this registry prior to hiring a worker and every six months thereafter to assure that no existing workers have had a finding placed against them.

• The Department of Health and Hospitals, Health Standards Section has a contractor who maintains the Direct Service Worker Abuse Registry for the state. Health Standards has a RN Program Manager who administers the Direct Service Worker Abuse Registry Program with oversight of the contractor.

• Each licensed provider is required to conduct the screening against the registry to assure a finding is not placed prior to employment and every six months thereafter to assure a finding is not placed in accordance with the Direct Service Worker Registry Final Rule published on April 20, 2011 Louisiana Registry.

• On each survey conducted at a provider agency, a sample of employee personnel files is pulled. Those files will be reviewed for compliance with any screenings that are required by regulations. If the provider is found to be not in compliance with the requirements, they will be cited and an acceptable plan of correction to assure on-going compliance will be required.

Appendix C: Participant Services

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

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

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

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

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Shared Living	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

For provider owned or controlled settings, the setting must be physically accessbile to participants.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Dental	
Respite Services - Out of Home	
One-Time Transitional Services	
Assistive Technology/Specialized Medical Equipment and Supplies	
Companion Care	
Environmental Accessibility Adaptations	
Housing Stabilization Service	
Host Home	
Nursing	
Prevocational Services	
Transportation - Community Access	
Supported Employment	
Personal Emergency Response System	
Shared Living Services	
Professional Services	
Day Habilitation	
Support Coordination	
Housing Stabilization Transition Service	
Community Living Supports	

Facility Capacity Limit:

6

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

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

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

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

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C -2-d. *Select one*:

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

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

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

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

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

Louisiana chooses to allow payments only to relatives in the situations described below:
Payments for any type of ROW services, including services provided under the self-direction option, are not allowed to:

- Parent(s) of a minor child;
- Legal guardian of an adult or child with developmental disabilities;
- Parent(s) for an adult child regardless of whether or not the adult child has been interdicted; or
- Spouse

In order to receive payment for provision of ROW services, relatives (other than those legally responsible individuals described above) must meet the criteria for the provision of the service and the same provider qualifications specified for the service(s) as other providers not related to the participant. In addition, relatives who provide services also must meet the following criteria:

- Become an employee of the participant's chosen waiver provider agency; or
Become a Medicaid enrolled provider agency; or

If the self-direction option is used, the relative must become an employee of the self-direction participant; and

• The relative must have a Medicaid provider agreement executed by the fiscal/employer agent, as authorized on behalf of the Medicaid agency.

Also, payments are not allowed to relatives (or any type of providers) who live in the same home/residence as the waiver participant except when a relative is providing Host Home or Companion Care services as justified below:

• Host Home:

o The nature of Host Home services requires that the waiver participant (especially children)receive their therapeutic based services in a family environment which is most appropriate for their treatment, normalization and progress. Therefore, a relative acting as a waiver participant's Host Home Family must live in the same home as the participant. The relative acting as Host Home Family will support the participant to live in the relative's home. The Host Home Family is the person or family who owns or leases the Host Home and provides day to day services to the participant. The Host Home Provider is the provider agency that recruits, trains, manages and monitors the Host Home Family. Relatives may serve as either the Host Home Family or the Host Home Provider agency, but not both. Relatives cannot live in the same home/residence as the waiver participant and serve as the participant's Host Home Provider agency. Assurance that payments are made only for services rendered is accomplished through OCDD Regional Waiver Supports and Services Offices or Human Services Authorities or Districts approval of the service on the Plan of Care as a prerequisite to prior and post authorization of the service for payment.

• Companion Care:

o The nature of Companion Care services requires that a waiver participant lives in an apartment or home with a roommate who shares expenses and provides support services including being on-call as needed in order to promote independence. The relative employed as the companion must be at least 18 years of age and must live with the participant. The relative employed as the companion is responsible for maintaining records in accordance with the state and provider requirements. Relatives may serve as either the companion or the Companion Care provider agency, but not both. Relatives cannot live in the same apartment, home/residence as the waiver participant and serve as the participant's Companion Care provider agency. The function of the Companion Care provider agency is to employ and supervise the companion and to facilitate the written agreement between the companion and waiver participant. The Companion Care provider agency also is responsible for 24-hour and back-up services. Assurance that payments are made only for services rendered is accomplished through OCDD Regional Waiver Supports and Services Offices or Human Services Authorities or Districts approval of this service on the Plan of Care as a prerequisite to prior and post authorization of the service for payment.

Other policy.

Specify:

---

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

Willing and qualified providers can access information regarding becoming an enrolled waiver service provider in several ways:

• Via the Louisiana Medicaid website;

• Through state facilitated stakeholder meetings regarding waiver services; and

• Through state facilitated meetings with provider organizations such as ARC of Louisiana, Community and Residential Services Association, Alliance of Direct Support Professionals, and Alliance of Support Coordinators.

To date, Louisiana has not experienced a problem in finding enough willing and qualified providers to enroll as waiver service providers.

As per the Interagency Agreement between the Medicaid Bureau of Health Services Financing (BHSF) and the OCDD:

• All willing and qualified providers have the opportunity to enroll as waiver service providers by first obtaining a license for the specific service they wish to provide through the Medicaid Bureau of Health Standards Section (BHSS);

• After obtaining a license, the provider applicant must complete a Medicaid Enrollment Application and sign a Louisiana Provider Enrollment form (PE-50) to enroll and participate in the Medicaid program;

• BHSF, or its designee, reviews all information, and makes a determination whether to enroll the provider in the Medicaid program;

• BHSF, or its designee assigns each new enrolled provider a unique Medicaid provider number and sends the OCDD/WSS this information;

• The Provider's name is then added to the Freedom of Choice list;

• BHSF trains all DD waiver providers in licensing and certification procedures and requirements;

• BHSF, OCDD, or its agent train DD waiver providers in the proper procedures to follow in submitting claims to the Medicaid program BHSF handles all questions concerning the submission of claims;

• BHSF/HSS is responsible for insuring that DD waiver providers remain in compliance with all rules and regulations required for participation in the Medicaid program; and

• HSS, or its designee notifies OCDD State Office in the event any previously enrolled waiver services provider is removed from the active Medicaid provider files. This notification includes the effective date of the closure and the reason.

All prospective providers must go through a licensing and a Medicaid provider enrollment on-site visit. The provider is listed on the Provider Freedom of Choice form for regions of the state for which they have completed enrollment and licensure. HSS (Health Standards Section) notifies the OCDD State Office when an enrolled provider is removed from the active Medicaid provider file and requires removal from the Freedom of Choice list. Notification will include the reason and the date of closure.

The time frame for obtaining a license is approximately three to four months once a provider has submitted a completed application and paid the required fee. Once the licensing process is completed, the enrollment process takes 15 working days from receipt of a completed enrollment application form.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
C.a.i.a.1. Number and percentage of initial provider applications for which the provider obtained appropriate, according to state policy and timelines, licensure/certification in accordance with State law prior to service provision. Percentage = number of initial providers who obtained appropriate licensure/certification prior to service provision / total number of initial providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider performance monitoring

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

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

Data Aggregation and Analysis:

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

Performance Measure:
C.a.i.a.2. Number and percentage of providers who meet applicable licensure/certification following initial enrollment, according to state policy and timelines. Percentage = number of providers who meet applicable licensure/certification standards / total number of providers surveyed.

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

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

		Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
C.a.i.a.3. Number and percentage of agency providers whose direct support staff had timely, as defined as occuring prior to providing direct care services, background checks. Percentage = Number of agency providers whose direct support staff had timely background checks / Total number of agency providers surveyed.

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
C.a.i.b.1. Number and percentage of unlicensed providers who meet Medicaid enrollment requirements. Percenage = Number of unlicensed providers who meet Medicaid enrollment requirements / Total number of unlicensed provider applicants.

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

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

Other Specify: Medicaid data contractor	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
C.a.i.b.2 Number and percentage of direct service workers (for self-direction participants) screened by the fiscal agent who were eligible for hire due to passing a criminal background check. Percentage = Number of direct service workers screened who passed a criminal background check / Total number of direct service workers hired.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Criminal background check reports

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

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

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

Responsible Party for data collection/generation(*check each that applies):*	**Frequency of data collection/generation**(*check each that applies):*	**Sampling Approach**(*check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 100% review of 4 random background check reports each quarter
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

Performance Measure:
C.a.i.c.1. Number and percentage of waiver direct service providers who meet the Health Standards Section licensing regulations for staff training, initial and annual continuing education requirements. Percentage = Number of waiver direct service providers who meet the training requirements / Total number of licensed waiver direct service providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Training Verification Records

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

Data Source (Select one):
Other

If 'Other' is selected, specify:
State Licensing Agency

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

Data Aggregation and Analysis:

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

Performance Measure:
C.a.i.c.2. Number and percentage of self-direction employees who meet training requirements. Percentage = Number of self-direction employees who meet training requirements / Total number of self-direction employees.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

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

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

For every deficiency cited, the provider will be required to submit a plan of correction. If acceptable, a follow up survey will be conducted. This will be accomplished either via onsite visit or via written evidence submitted by the provider, depending on the deficiencies. The plan of correction will require the provider to give a completion date (no more than 90 days) for each deficiency as well as identify the staff person responsible for monitoring and assuring continued compliance. Failure to come into substantial compliance could result in license revocation and or cancellation of the Medicaid provider agreement. Civil monetary penalties may be imposed for deficiencies resulting in actual harm or death to a client or when there are repeat deficiencies within 18 months. Failure to pay the fine will result in withholding the money.

If a provisional license is issued, the provider will be reviewed at the end of the provisional license period for compliance history. If the provider is still not in compliance, a revocation action will be initiated.

Providers who do not provide staff with orientation and on-going in-service training as per the licensing standards will be cited with deficiencies and subject to the remediation procedures stated above.

The Regional Offices will contact the support coordination agencies for follow up with issues or concerns related to providers or the participants receiving services from these providers. Remediation activities may include meeting with providers to resolve concerns and conducting additional training with providers. If ongoing reviews conducted by the Regional Offices or State Quality Assurance Team reveal ongoing concerns with provider performance, providers will be required to develop plans of correction within specific time frames to correct the problems. The Quality Assurance Team and/or the Regional Offices will conduct follow up activities to ensure that corrections are sustained.

Remediation will be required for each area of non-compliance and may include sanctions, plans of corrections, issuance of provisional license, license revocation, or civil monetary penalties.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

The Inventory for Client and Agency Planning (ICAP) is a standardized assessment instrument that is designed to assess the status, adaptive functioning, and service needs of an individual. The ICAP is applicable to participants of all ages (infant to adult). Information is obtained from the participant's family, advocate, and/or direct care staff.

The ICAP score for a participant is used to determine the participant's level of support needs which is then used to determine the

participant's individual budget level. If a participant's level of support needs change, the ICAP is readministered to determine the participant's budget change.

Support levels used in the ROW as identified by classification in the ICAP:

- Intermittent – supports on an as needed basis. Characterized as episodic in nature, the person does not always need the support(s), or short-term supports needing during life-span transition.
- Limited – supports characterized by consistency over time, time-limited but not of an intermittent nature.
- Extensive – supports characterized by regular involvement (e.g., daily) in at least some environments and not time-limited.
- Pervasive – supports characterized by their constancy, high intensity, provision across environments, and potential life-sustaining nature.

In addition to being the primary component of budget setting, the ICAP provides information used to identify support needs in the participant's Plan of Care. The support coordinator includes the participants support needs and budget level in the Plan of Care.

Geographic factors do not affect the budget amount.

A participant who contests their score may participate in anICAP assessment. If participant continues to oppose the results, an appeal can be filed through the Administrative Law forum established by the Department of Health and Hospitals' Office of the Secretary (process used for all Medicaid appeals). The Administrative Law Judge's (ALJ) finding/ruling is considered "public record" in Louisiana. If the participant wishes to make a further appeal after ALJ's findings/ruling, an appeal can be made to the State District Court requesting a "Petition for Judicial Review" which is also considered "public record."

If the participant needs cannot be met within the highest cost limits of the ROW, all Medicaid services options will be explored, including ICF's/DD.

☐ **Other Type of Limit.** The State employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Plan of Care

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

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

Specify qualifications:

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

• Following selection of and linkage to a Support Coordinator agency, the assigned Support Soordinator explains all available services in the waiver during the initial contact so that the participant and his/her family/legal representatives can make informed choices. The participant is also informed of any procedural safeguards, their rights and responsibilities, how to request a change of Support Coordination agencies or Direct Service Providers, and the grievance and/or complaint procedures. Printed information is given to the participant at this visit. The Support Coordinator provides assistance in gaining access to the full range of needed services including medical, social, educational, and/or other supports as identified by the participant.

• The initial planning meetings are conducted in a face-to-face visit in the participant's place of residence. During the initial visit, the participant chooses who will be part of his/her planning process. The Support Coordinator assists the participant/family in contacting the team members with the date(s) and time(s) of meeting(s). The Support Coordinator facilitates the planning meeting with the participant/family driving the planning process.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

A. PLAN OF CARE (POC) DEVELOPMENT AND TIMING

• An Inventory for Client and Agency Planning (ICAP) is completed initially and as needed and is required prior to developing the Plan of Care.

• The Plan of Care is developed through a collaborative process which includes the Support Coordinator, participant and his/her family and friends, legal representatives, appropriate professionals/service providers, and others whom the participant chooses to be involved. This group is hereafter referred to as the support team.

• Initial Support Coordinator contact with the participant occurs within 3 business days of being linked to the Support Coordination agency of choice.

• For initial participants, the Plan of Care development process must begin within seven (7) calendar days following linkage to the Support Coordination agency of the participant's choice.

• The Support Coordinator contacts the participant and/or his/her family/authorized representative to schedule the initial, annual, and any subsequent support planning meeting at a time and place that is convenient to the participant and/or his/her family/authorized representative.

• The Support Coordinator is required to submit the complete initial Plan of Care to the appropriate OCDD Regional Waiver Supports and Services Office or Human Services Authority or District within thirty-five (35) days following linkage and then annually prior to the expiration of the annual Plan of Care.

• The OCDD Regional Waiver Supports and Services Office or Human Services Authority or District staff has ten (10) business days to review the information, complete the precertification home visit and approve the Plan of Care prior to waiver services beginning.

• At least quarterly, the Support Coordinator and the participant/family, and others the participant/family chooses to be present, review the Plan of Care to determine if the goals identified in the Plan of Care are being achieved, if the participant's/family's needs including health and welfare are being addressed, and to make any adjustments or changes to the Plan of Care as necessary.

• The entire support team meets annually to review and revise the participant's Plan of Care for the new Plan of Care year. The annual date of the Plan of Care does not change, even if there has been a more recent meeting to revise the services within the Plan of Care.

B. ASSESSMENTS

The Developmental Disabilities Support Needs Assessment Profile (DD SNAP) and the Inventory for Client and Agency Planning (ICAP) are completed for all applicants to the Louisiana developmental disability system. As appropriate other standardized assessments ((i.e., test of intellectual functioning (Wechsler Series of Intelligence Test and Stanford-Binet Intelligence Scales) and test of adaptive functioning (Vineland Adaptive Behavior Scales)) are used during the systems entry process to determine if an applicant has an intellectual or developmental disability. Information from the above assessments, as appropriate, is used in the development of the Plan of Care.

The needs-based assessments described below are completed within the discovery process for all applicants to identify the individual's service needs. Discovery activities include:

• An ICAP which is completed initially and as needed and is required prior to developing the Plan of Care.
• A review of the participant's records relevant to service planning (i.e. school, vocational, medical, psychological records, etc.)
• A personal outcomes assessment, which assists the planning team in determining personal goals and desired personal outcomes
• A review and/or completion of any additional interviews, observations, or other needed professional assessments (i.e. occupational therapy, physical therapy, speech therapy, nutritional, etc.)

In addition, the needs-based assessments described below may be completed within the discovery process for all applicants to provide additional information to assist in identifying the individual's service needs. Discovery activities may include the completion and review of the Supports Intensity Scale (SIS) and Louisiana PLUS (LA PLUS) assessments.

• The Supports Intensity Scale (SIS) is a standardized assessment tool designed to evaluate the practical support requirements of people with developmental disabilities. The SIS measures support needs for 85 different activities in the areas of home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy. The SIS then rates each activity according to frequency, amount, and type of supports needed.

• The Louisiana PLUS (LA PLUS) is a complimentary assessment tool designed to identify support needs and related information not addressed by the SIS. The LA PLUS is used to evaluate a person's support needs based on information and data collected from four areas of the person's life, including:
  o Other support needs – material supports; hearing-related supports; supports for communicating needs; and stress and risks factors.
  o Living arrangements
  o Medical and diagnostic information
  o Personal satisfaction reports – supports at home; work/day programs; living environment; family relationships; and social relationships.

Information obtained through the discovery process is shared with the support team in preparation for the Plan of Care meeting and result in an individualized Plan of Care.
Based on the findings of the discovery activities described above a Plan of Care is developed.

A reassessment may be conducted at any time, particularly with a significant life change, but must be completed at least annually. The assessment process is intended to be ongoing and designed to reflect changes in the participant's life, needs, and personal outcomes, inclusive of his/her preferences

If the participant disagrees with the proposed services in the Plan of Care the participant or his/her family/authorized representative may request additional services and present supporting documentation. If the participant or his/her family/authorized representative is not satisfied with the decision related to the request for additional services, then he/she may appeal any limit or denial of services through the Department of Health and Hospitals, Bureau of Appeals' process as referenced in Appendix F-1, Opportunity to Request a Fair Hearing.

C. HOW PARTICIPANTS ARE INFORMED OF AVAILABLE SERVICES

The Support Coordinator informs the participant and his/her family/authorized representative of all available waiver services during the initial contact with the Support Coordination agency, in quarterly meetings as needed, on an annual basis during the Plan of Care development process, and as requested.

D. INCORPORATION OF PARTICIPANT GOALS/NEEDS/PREFERENCES IN THE PLAN OF CARE

The following components are designed to incorporate the participant's goals, needs, and preferences in the Plan of Care:

- Discovery, which involves gathering information about the participant's interests, goals, preferences, and support needs through assessments and interviews. The discovery process ends with the formulation of the participant's vision and goals.
- Planning. This involves using the information from the discovery process to develop the Plan of Care. During the planning process, the support team works with the participant to develop strategies to assist him/her in achieving his/her goals and support needs. Strategies should identify all supports needed to assist the participant in achieving his/her goals and meeting other identified support needs and an appropriate action plan. For each personal outcome/goal identified, the support team will identify the following: the participant's strengths, skills, abilities that can be used to achieve his/her goals; challenges, barriers, health issues, or risk factors that can be deterrents to meeting his/her goals; strategies, treatments, or trainings which can be implemented to overcome barriers; any opportunities available for increasing the participant's independence in achieving his/her goals.
- Implementation, which involves the completion of noted strategies and provision of needed supports according to the participant's Plan of Care.

E. COORDINATION OF SERVICES

The planning process requires the identification and utilization of all appropriate supports available to the participant prior to the support team considering waiver services.
Services are coordinated through the participant's Support Coordinator. The Support Coordinator leads the support team in developing a Plan of Care with and for the participant. The Plan of Care must include the following required components:

- The participant's prioritized personal goals and specific strategies to achieve or maintain his/her desired personal goals. These strategies will focus first on the natural and community supports available to the participant and, if needed, paid services will be accessed as a supplement to natural and community supports.
- An action plan which will lead to the implementation of strategies to achieve the participant's personal goals, including action steps, review dates, and the names of the persons who are responsible for specific steps.
- Identified barriers, including health and safety risks, and specific strategies with timelines and the persons assigned to specific responsibilities, to address each issue.
- All the services and supports the participant receives, regardless of the funding source which may include natural support networks, generic community services, and state plan services.
- Identification of the frequency and location of services through a daily and alternate schedule.
- Identification of providers and specification of the service arrangement.
- Identification of the support team members who will assist the support coordinator in the planning process, as well as building and implementing supports for the participant.
- Signature of all support team members present in the planning meeting to indicate their agreement with the Plan of Care.

F. ASSIGNMENT OF RESPONSIBILITIES TO IMPLEMENT AND MONITOR PLAN OF CARE

Each participant's Plan of Care includes multiple strategies and actions to achieve his/her life vision and goals, while addressing key support needs. The support team is responsible for:

- Identifying any necessary training the participant's family or staff need in order to implement the actions and strategies described in the Plan of Care and determining who will provide the necessary training.

- Identifying any resources needed by the participant's family or staff to implement the actions and strategies described in the Plan of Care and determining who will provide or acquire the needed resources.

In addition, the Support Coordinator is required to make a monthly contact with participant and visit the participant in his/her home once per quarter to monitor the implementation of the Plan of Care, the participant's satisfaction with services, and to determine if the participant has any new interests, goals, or needs.

The Support Coordinator is responsible for reviewing the information on the Plan of Care, tracking progress on identified goals and timelines, and obtaining updated information on the participant's natural supports. This includes monitoring how individual providers (e.g. vocational, supported living) implement their portion of the participant's Plan of Care so that all relative goals and objectives are achieved.

During the quarterly monitoring reviews, the support team will review various data sources related to the participant's goals and objectives

in order to determine if progress has been made.

G. HOW AND WHEN PLAN IS UPDATED

At least quarterly, the support team meets to review the Plan of Care to determine if the participant's goals have been achieved, if the participant's needs are being met, and to make any adjustments to the Plan of Care.

The Plan of Care must be updated at least annually or as necessary to meet the participant's needs. The completed, updated, annual Plan of Care must be submitted to the appropriate OCDD Regional Waiver Supports and Services Office or Human Services Authority or District no later than thirty five (35) days prior to expiration of the previous Plan of Care.

At any time that the Support Coordinator or any other support team member identifies a condition related to the participant's health status, behavioral change, or any other type of change which is not satisfactorily addressed or which requires updated discussion or planning, the support coordinator will immediately reconvene the support team to revise the Plan of Care to reflect the participant's revised needs and desired outcomes. This change in the participant's condition or health status, behavior or other change may or may not have been identified through re-assessment of the ICAP but may have recently surfaced, been identified through the participant's primary care physician, or been identified through periodic monitoring.

Emergency revisions must be submitted by the support coordinator to the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District within twenty-four (24) hours or by the next working day. Revisions that include routine changes, such as planned vacations, must be submitted by the Support Coordinator at least seven (7) days prior to the change.

Appendix D: Participant-Centered Planning and Service Delivery

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

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Information from various assessments conducted during the planning process is used to identify any potential risks, which are then addressed through mitigation strategies that are included in the Plan of Care.

In addition, information gained during interviews with the participant and his/her legal representatives and support team members, as well as information from the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District pre-certification visit is also used during the initial planning process to identify potential risks to the participant.

- The participant and all support team members are given informed choice regarding the inclusion of any strategies recommended to be included in an initial or revised Plan of Care. The initial or revised Plan of Care with the included strategies must be signed and dated by all support team members.

- Recommendations from support team members on strategies to mitigate specific risk are incorporated into the Plan of Care. The OCDD Regional Waiver Supports and Services Office or Human Services Authority or District reviews recommendations, makes additional recommendations, and/or refers the issue to the OCDD State Office for input prior to approval of an initial or revised Plan of care.

The direct service provider is responsible for completing an emergency evacuation plan and back- up plan for each participant. Both are submitted to the Support Coordinator during the Plan of Care development process. The Support Coordinator is responsible for submitting the back-up plan and emergency evacuation plan to The OCDD Regional Waiver Supports and Services Office or Human Services Authority or District along with the participant's Plan of Care. The OCDD Regional Waiver Supports and Services Office or Human Services Authority or District ensures that the back- up plan and emergency evacuation plan are in place and will not approve the Plan of Care without these documents.

BACK-UP STAFFING PLANS

- Support Coordinators are to ensure that back-up and emergency evacuation plans are in place.

- All enrolled providers of waiver services must possess the capacity to provide the support and services required by the participant in order to insure the participant's health and safety as outlined in the Plan of Care, and are required to have functional Individualized Back-Up Plans consistent with the participant's Plan of Care. When paid supports are scheduled to be provided by an enrolled provider of waiver services, that provider is responsible for providing all necessary staff to fulfill the health and safety needs of the participant.

- The identified enrolled provider of waiver services cannot use the participant's informal support system as a means of meeting the agency's individualized back-up plan, and/or emergency evacuation response plan requirements unless agreed to by the participant/family because the family prefers to make other arrangements.

- The identified enrolled provider of waiver services must have in place policies and procedures that outline the protocols the agency has established to assure that back-up direct support staff are readily available, lines of communication and chain-of-command have been established, and procedures are in place for dissemination of the back-up plan information to participants, their legal representatives, and support coordinators.

- It is the identified enrolled provider of waiver services' responsibility to develop the back-up plan and provide it to the Support Coordinator in a time frame that will allow it to be submitted for review/approval as a part of the Plan of Care.

- The Support Coordinator is responsible for working with the participant, his/her family, friends, and providers during initial and subsequent Plan of Care meetings to establish plans to address these situations.

- The Support Coordinator assists the participant and the support team members to identify individuals who are willing and able to provide a back-up system during times when paid supports are not scheduled on the participant's Plan of Care.

- All back-up plans must include detailed strategies and person-specific information that addresses the specialized care and supports needed by the participant as identified in the Plan of Care. Back-up plans must be updated no less than annually to assure information is kept current and applicable to the participant's needs at all times.

EMERGENCY EVACUATION PLANS
An Emergency Evacuation Response Plan must be developed in addition to the individual back-up plan, be included in or attached to the participant's Plan of Care, and reviewed a minimum of once each Plan of Care year.

The Emergency Evacuation Response Plan provides detailed information for responding to potential emergency situations such as fires, hurricanes, hazardous materials release, tropical storms, flash flooding, ice storms, and terrorist acts.

The Emergency Evacuation Response Plan must include at a minimum the following components:
- Individualized risk assessment of potential health emergencies;

- Geographical and natural disaster emergencies, as well as potential for any other emergency conditions;

- A detailed plan to address participant's individualized evacuation needs

Policies and procedures outlining the agency's protocols regarding implementation of Emergency Evacuation Response Plans and how these plans are coordinated with the local Office of Emergency Preparedness and Homeland Security;

Establishment of effective lines of communication and chain-of-command, and procedures for dissemination of Emergency Response Plan to participants and Support Coordinators; and
Protocols outlining how and when direct support staff and participants are to be trained in Emergency Evacuation Response Plan implementation and post-emergency protocols.
Training for direct support staff must occur prior to any worker being solely responsible for the support of the participant, and participants must be provided with regular, planned opportunities to practice the emergency evacuation response plan.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

On acceptance of the waiver offer, the data management contractor offers Freedom of Choice of Support Coordination agencies.

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

At initial contact and annually with the participant, the Support Coordinator discusses the Provider Freedom of Choice form and the availability of all services. The Support Coordinator is responsible for offering Freedom of Choice of providers.

Part of this contact involves a discussion of Freedom of Choice of enrolled waiver providers, the availability of all services, as well as what the participant and his/her legal representatives require from Support Coordination. The Freedom of Choice list includes all providers in the participant's region that are enrolled to provide specific waiver services. The Support Coordinator is responsible for maintaining a current listing of qualified providers.

The Support Coordinator is responsible for advising the participant that changes in providers can be requested at any time, but only by the participant or personal representative. The Support Coordinator will facilitate any request for a change of all providers.

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

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

The Support Coordinator is not allowed to make recommendations and does not coerce the participant/family in making his/her decision.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Through a Memorandum of Understanding (MOU) with the Operating Agency (OCDD), the Medicaid agency (BHSF) has delegated approval of Plans of Care to the operating agency. This is done to assure that the operating agency is complying with all HCBS regulations related to service planning, is following the Residential Options Waiver Application requirements and is identifying areas of deficiency on the plans of care and implementing appropriate corrective actions. OCDD and BHSF will collaborate on any corrective actions as needed.

The Medicaid agency receives reports specific to the Residential Options Waiver which facilitate Medicaid's oversight of the service plan approval processes.

The following Operations Reports are generated quarterly from the Medicaid data contractor database: Program enrollment, LOC redeterminations, service plan timeliness, service utilization and made available directly to the Medicaid agency.

Participant Health & Welfare reports are generated from the MDS-HC Data Base & Medicaid Administrative Data Base annually and are submitted by OCDD to the Medicaid agency.

Mortality Reports are generated from the Medicaid Eligibility Data Base annually and are submitted by OCDD to the Medicaid agency.

Critical Incident Trend Report are generated quarterly from the Waiver OTIS Data Base and submitted by OCDD to the Medicaid agency.

Support Coordination Agency Monitoring Report: Support Coordination Agency Monitoring Data Base is generated annually and submitted by OCDD to the Medicaid agency.

HCBS Waiver Management Report: Trend and comparative abstract of data included in program operations report, critical incident trend report, and support coordination agency monitoring report. Frequency: annually.

These reports are reviewed and acted upon by the Cross-Waiver Quality Team which meets every other month and is composed of representatives from the Program Offices, Medicaid and DHH IT.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

- **Medicaid agency**
- **Operating agency**
- **Case manager**
- **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The Support Coordinator is responsible for monitoring the implementation of the Plan of Care, the participant's health and welfare and the effectiveness of the Plan of Care in meeting the participant's needs and preferences.

The Support Coordinator contacts the participant and his/her legal representative within 10 working days after the initial Plan of Care is approved to assure the appropriateness and adequacy of services delivery.

Support Coordinators make monthly contacts with each participant and/or his/her legal representatives. One contact per quarter must be a face-to-face visit in the participant's place of residence.

During these contacts the Support Coordinator checks to make sure that:

- There is access to waiver and non-waiver services identified in the Plan of Care, including access to health services;
- The strategies to meet the participant's personal goals are being implemented and the effectiveness of the strategies;
- The services outlined in the Plan of Care are meeting the needs of the participant;
- The participant is satisfied with the service providers he/she has chosen;
- Services are being furnished in accordance with the Plan of Care;
- The participant's health and welfare needs are being met; and
- Back-up plans, if utilized, are effective and persons identified as responsible for back-up plans are still active in the participant's life.

Information from Support Coordinator's monitoring is maintained at the Support Coordination Agency's physical office. Support Coordinators must refer any findings during contacts or visits that appear to be out of compliance with federal or state regulations, and OCDD policies to the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District for review and recommendations. If the finding cannot be resolved at the local level, OCDD Regional Waiver Supports and Services Office or Human Services Authority or District will refer it to the OCDD State Office to be resolved.

Revisions to the Plan of Care reflect the results of the monitoring. During the monitoring of the Plan of Care implementation, if changes are needed, a revision to the Plan of Care will be completed. All revisions must be reviewed and prior approved by the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District. Emergency revisions to the Plan of Care must be submitted to OCDD Regional Waiver Supports and Services Office or Human Services Authority or District within 24 hours or next business day. Routine revisions must be submitted to OCDD Regional Waiver Supports and Services Office or Human Services Authority or District within at least seven (7) days prior to the change.

If a participant receives a denial, reduction or termination of services, appeal information is provided to them as outlined in Appendix F, section F-1.

b. Monitoring Safeguards. *Select one:*

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

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

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

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ppendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:

D.a.i.a.2. Number and percentage of plans of care in which services and supports align with the participant's assessed risk. Percentage = Number of plans of care that meet the assessed risks of waiver participants / Total number of plans of care reviewed in the sample.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
D.a.i.a.3. Number and percentage of plans of care that address participants' personal goals. Percentage = Number of plans of care that address participants' personal goals / Total number of plans of care reviewed in the sample.

Data Source (Select one):

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
D.a.i.b.1. Number and percentage of plans of care that are developed in accordance with state requirements. Percentage = Number of plans of care that meet state requirements / Total number of plans reviewed.

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
D.a.i.c.1. Number and percentage of annual plans of care received prior to the expiration date of the approved plan of care. Percentage = Number of annual plans of care received by due date / Total number of plans of care due during reporting period.

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
D.a.i.d.1. Number and percentage of participants who received services in the amount, frequency and duration specified in their plan of care. Percentage = Number of participants who received services in the amount, frequency and duration specified in their plan of care / Total number of participants.

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.a.i.e.2. Number and percentage of waiver participants who received a choice of available waiver services providers, as documented by a signed and dated freedom of choice listing. Percentage = Number of participants offered choice of available waiver service providers / Total number of records reviewed in the sample.

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

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

Specify:

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Performance Measures D.a.i.a.1, D.a.i.a.2, D.a.i.a.3, D.a.i.b.1, D.a.i.c.1, D.a.i.e.1, and D.a.i.e.2: A random sample of participants whose plans were approved during the preceding quarter will be generated by OCDD. For each participant included, OCDD Regional Waiver Supports and Services Office or Human Services Authoritiy or District quality or supervisory staff will review participants records to obtain the information necessary for reporting these performance measures.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Performance Measures D.a.i.a.1, D.a.i.a.2, D.a.i.a.3, D.a.i.b.1, D.a.i.e.1, and D.a.i.e.2:

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

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

All aggregated discovery and remediation data is submitted by the operating agency to WCS on a quarterly basis for analysis. WCS also reviews the performance measure reports and monitors remediation activity on a quarterly basis to ensure all instances of non-compliance are remediated within 30 days of notification. WCS then monitors the data reports to see if remediation activities were effective in improving data results from the previous time period. If remediation activities were not effective, the SMA will meet with the operating agency to address any changes needed to remediation strategies in order to improve results. The SMA will continue to follow up with the operating agency to evaluate remediation for effectiveness.

ii. **Remediation Data Aggregation**

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

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

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

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

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

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

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunitie (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information abou the waiver's approach to participant direction.

Self-Direction is a service delivery option which allows participants (or their authorized representative) to exercise Employer Authority in the delivery of their authorized self-directed services(Community Living Supports).

Participants are informed of all available services and service delivery options, including Self-Direction, at the time of the initial assessment, annually, or as requested by participants or their authorized representative. Participants, who are interested in Self-Direction, need only notify their Support Coordinator who will facilitate the enrollment process.

A contracted fiscal/employer agent is responsible for processing the participant's employer-related payroll, withholding and depositing the required employment-related taxes, and sending payroll reports to the participant or his/her authorized representative.

Support Coordinators assist participants by providing the following activities:

- The development of the participant's Plan of Care;
- Organizing the unique resources the participant needs;
- Training participants on their employer responsibilities;
- Completing required forms for participation in Self-Direction;

- Back-up service planning;
- Budget planning;
- Verifying that potential employees meet program qualifications; and
- Ensuring participants' needs are being met through services.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or th co-employer of workers. Supports and protections are available for participants who exercise this authority.
- **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decisior making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- **Waiver is designed to support only individuals who want to direct their services.**
- **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

To be eligible, the participant must:

- Be able to participate in the Self-Direction option without a lapse in or decline in quality of care or an increased risk to health and welfare. Health and welfare safeguards are articulated in Appendix G of this document and include the application of a comprehensive monitoring strategy and risk assessment and management system.

- Complete the training programs (e.g. initial enrollment training) designated by OCDD.

- Understand the rights, risks, and responsibilities of managing his/her own care, effectively managing his/her Plan of Care; or if unable to make decisions independently have a willing decision maker (authorized representative as listed on the participant's Plan of Care) who understands the rights, risks, and responsibilities of managing the care and supports of the participant within their Plan of Care.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's

representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishin this information; and, (c) how and when this information is provided on a timely basis.

Participants are informed of the Self-Direction option at the time of the initial assessment, annually, or as requested by participants or their authorized representative. If the participant is interested, the Support Coordinator will provide more information on the principles of self-determination, the services that can be self-directed, the roles and responsibilities of each service option, and the benefits and risks of each service option, and the process for enrolling in Self-Direction.

Prior to enrolling in Self-Direction, the participant or his/her authorized representative is trained by the support coordinator on the material contained in the Self-Direction Employer Handbook. This includes training the participant (or his/her authorized representative) on the process for completing the following duties:

- Best practices in recruiting, hiring, training, and supervising staff;
- Determining and verifying staff qualifications;
- The process for obtaining criminal background checks on staff;
- Determining the duties of staff based on the service specifications;
- Determining the wages for staff within the limits set by the state;
- Scheduling staff and determining the number of staff needed.
- Orienting and instructing staff in duties;
- Best practices for evaluating staff performance;
- Verifying time worked by staff and approving timesheets;
- Terminating staff, as necessary;
- Emergency Preparedness planning; and
- Back-up planning.

This training also includes a discussion on the differences between Self-Direction and other service delivery options (which includes the benefits, risks, and responsibilities associated with each service option) and the roles and responsibilities of the employer, support coordinator, and fiscal/employer agent.

Participants who choose Self-Direction are provided with a copy of the Self-Direction Employer Handbook by the Support Coordinator or OCDD. Participants verify that they have received the required training from their support coordinator and a copy of the Self-Direction Employer Handbook by signing the "Service Agreement" form.

The Self-Direction Employer Handbook was developed through contribution and feedback from participants and families to ensure that the information is easy-to-understand and addresses participants' perspective.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☐ **Waiver services may be directed by a legal representative of the participant.**
- ☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

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g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Community Living Supports	☐	☐

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h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participan direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

- ☐ **Governmental entities**
- ☐ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Iten E-1-i.*

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i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Fiscal management services are provided by a contracted fiscal/employer agency, procured through the Department's Request for Proposal (RFP) process.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The charges for fiscal management services will be paid through a monthly fee per participant by the Bureau of Health Services Financing (BHSF).

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- ☑ **Assist participant in verifying support worker citizenship status**
- ☐ **Collect and process timesheets of support workers**
- ☐ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes an insurance**
- ☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- ☐ **Maintain a separate account for each participant's participant-directed budget**
- ☐ **Track and report participant funds, disbursements and the balance of participant funds**
- ☐ **Process and pay invoices for goods and services approved in the service plan**
- ☐ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

Specify:

Additional functions/activities:

- ☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☐ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☐ **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The Bureau of Health Services Financing (BHSF) is responsible for the monitoring of the performance and financial integrity of FMS and the terms of the contract. BHSF performs monitoring of the fiscal/employer agent's claims payment activities, billing history, and adherence to the terms of the contract on an on-going basis. OCDD provides BHSF with any data or other relevant information regarding the fiscal/employer agent's performance. If any problems are identified (regardless of the origination of issue), BHSF will require a corrective action plan from the fiscal/employer agent and will monitor its implementation.

Semi-monthly statements of participants' employer related payroll activities are sent to the participant, BHSF, and OCDD for review to monitor the utilization of Plan of Care units and payments.

In addition, BHSF requires that the fiscal/employer agent submit an annual independent audit by a Certified Public Accountant (CPA) to verify that expenditures are accounted for and disbursed according to generally accepted accounting principles.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnishe by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunit under the waiver:

Support Coordinators will inform participants of the Self-Direction option at the time of initial assessment, annually, and as requested by participants or their authorized representative. If participants or their authorized representative are interested, the Support Coordinator shall provide detailed information regarding the differences between service delivery options, roles and responsibilities in Self-Direction, and benefits and risks associated with Self-Direction. The Support Coordinator is responsible for providing the participant or their authorized representative with the Self-Direction Employer Handbook.

If the participant decides that he/she would like to participate in this option, the support coordinator shall notify the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District and the Self-Direction Program Manager. Once notified by OCDD that the participant is eligible to participate in Self-Direction, the Support Coordinator facilitates the scheduling of the initial Self-Direction planning meeting.

The Support Coordinator will assist participants and their authorized representative with determining the number of direct care workers needed, preparing and completing of required forms as needed, determining what resources the participant will need to participate in Self-Direction, and arranging for other needed supports and services. The Support Coordinator will be responsible for training the participant (or his/her authorized representative) on the material contained in the Self-Direction Employer Handbook, which includes information on recruiting, hiring, and managing staff, with the participant.

The Support Coordinator will then facilitate planning and preparation of the Plan of Care/revision, which will be submitted to the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District for approval. Support Coordinator is responsible for monitoring service delivery and implementation dates, and updating the participant's Plan of Care annually or as

changes in service needs occur. The OCDD Regional Waiver Supports and Services Office or Human Services Authority or District will approve changes as needed.

Support Coordinators also act as a resource and advocate for the participant in identifying and obtaining formal and informal supports, assist the participant in working with the fiscal/employer agent, and provide employment support to participants inclusive of the duties specified in Appendix E-2-a-ii.

☐ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Dental	☐
Respite Services - Out of Home	☐
One-Time Transitional Services	☐
Assistive Technology/Specialized Medical Equipment and Supplies	☐
Companion Care	☐
Environmental Accessibility Adaptations	☐
Housing Stabilization Service	☐
Host Home	☐
Nursing	☐
Prevocational Services	☐
Transportation - Community Access	☐
Supported Employment	☐
Personal Emergency Response System	☐
Shared Living Services	☐
Professional Services	☐
Day Habilitation	☐
Support Coordination	☐
Housing Stabilization Transition Service	☐
Community Living Supports	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

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k. Independent Advocacy *(select one).*

No. Arrangements have not been made for independent advocacy.

Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

All waiver participants have access to independent advocacy through the Advocacy Center in Louisiana.

The Advocacy Center has a multi-disciplinary staff of lawyers, paralegals, client advocates and support staff who provide the following services: Legal Representation, Advocacy Assistance, Information and Referral, Systems Advocacy, Education and Training, Self-Advocacy, Publications, and Outreach.

The Advocacy Center is Louisiana's protection and advocacy system. Federal law requires that a protection and advocacy system operate in every state to protect the rights of persons with mental or physical disabilities. The Advocacy Center is also funded by the state to provide legal assistance to people residing in nursing homes in Louisiana and to advocate for the rights of group home and nursing home residents. Among the diverse services offered are legal representation, information and referral, outreach and training. The Advocacy Center also provides limited legal services as well as outreach and education to senior citizens of Orleans, Plaquemines and St. Tammany under contract with the Councils on Aging in those parishes.

The Advocacy Center helps to give clients the skills and knowledge to act on their own behalf. The Advocacy Center provides a variety of booklets, reports, flyers, and other resources pertaining to persons 60 years or older and persons with disabilities. The Advocacy Center does not provide other direct services or perform waiver functions that have a direct impact on a participant.

Support Coordinators are responsible for informing participants of the availability of independent advocacy.

Appendix E: Participant Direction of Services

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l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Selection of the Self-Direction option is strictly voluntary and the participant may choose at any time to withdraw and return to traditional payment option. Withdrawal requires a revision of the Plan of Care, eliminating the FMS and indicating the Medicaid-enrolled waiver service provider of choice. Procedures must follow those outlined in the Support Coordination Manual. Proper arrangements will be made by the support coordinator to ensure that there is no lapse in services.

Should the request for voluntary withdrawal occur, the participant will receive counseling and assistance from his/her Support Coordinator immediately upon identification of issues or concerns in any of the above situations

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m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Involuntary termination requires a revision of the Plan of Care, eliminating the fiscal/employer agency and indicating the Medicaid-enrolled waiver service provider of choice. Procedures must follow those outlined in the Support Coordination Manual.

Involuntary termination may occur for the following reasons:

- If the participant does not receive self-directed services for ninety days or more.

- If at any time OCDD determines that the health, safety, and welfare of the participant is compromised by continued participation in the Self-Direction option, the participant will be required to return to the traditional payment option.

- If there is evidence that the participant is no longer able to direct his/her own care and there is no responsible representative to direct the care and the Support Coordinator agrees, then the participant will be required to return to the traditional payment option.

- If the participant or the authorized representative/co-signer consistently:

  o Permits employees to work over the hours approved in the participant's Plan of Care or allowed by the participant's program

  o Places barriers to the payment of the salaries and related state and federal payroll taxes of direct support staff, as documented by the fiscal/employer agent.

  o Fails to provide required documentation of expenditures and related items, or fails to cooperate with the fiscal/employer agent or support coordinator in preparing any additional documentation of expenditures, as documented by the fiscal/employer agent and/or the Support Coordinator.

  o Violates Medicaid program rules or guidelines of the of the Self-Direction option.

- If the participant becomes ineligible for Medicaid and/or home and community-based waiver services, the applicable rule for case closure/discharge will be applied.

- If there is proof of misuse of public funds.

When action is taken to terminate a participant from Self-Direction involuntarily, the Support Coordinator immediately assists the