Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
A language service vendor is under contract with LDH. All Medicaid application forms are published in English, Spanish, and Vietnamese and are available in alternative format upon request.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Center-Based Respite		
Statutory Service	Support Coordination		
Extended State Plan Service	Specialized Medical Equipment and Supplies		
Other Service	Aquatic Therapy		
Other Service	Art Therapy		
Other Service	Environmental Accessibility Adaptations		
Other Service	Family Support Services		
Other Service	Family Training		
Other Service	Hippotherapy/Therapeutic Horseback Riding		
Other Service	Housing Stabilization Service		
Other Service	Housing Stabilization Transition Service		
Other Service	Music Therapy		
Other Service	Sensory Integration		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):
Center-Based Respite

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):*
Center-based respite care is a service provided to participants who are unable to care for themselves; furnished on a short-term basis due to the absence or need for relief of those persons normally providing the care. Respite care will only be provided in a licensed center-based respite care facility. It is most commonly used when families take vacations, go away for the weekend, or have a sudden emergency such as a death in the family. It is not substitute family care, foster home placement, or day care. Licensing requirements provide that bedrooms be occupied by one to four persons of appropriate age and sex; separate bathrooms be available for males and females; and three meals a day and snacks be provided. Services are provided according to the plan of care that takes into consideration the specific needs of the participant.

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

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

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

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	HCBS-Center-Based Respite Module

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Center-Based Respite

Provider Category:
Agency
Provider Type:
HCBS-Center-Based Respite Module
Provider Qualifications
License *(specify):*
Home and Community Based Services Provider Licensing Standards-LAC 48:1, Chapter 50; January 20, 2012
Certificate *(specify):*
N/A
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

Louisiana 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:
Statutory Service

Service:
Case Management

Alternate Service Title (if any):
Support Coordination

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):*
Support Coordination consists of the coordination of supports and services that will assist participants who receive Louisiana Children's Choice Waiver services in gaining access to needed waiver and other Medicaid services, as well as needed medical, social, educational and other services, regardless of the funding source. The support coordinator is responsible for convening the person-centered planning team comprised of the participant, participant's family, direct service providers, medical and social work professionals, as necessary, and advocates, who assist in determining the appropriate supports and strategies to meet the participant's needs and preferences. The support coordinator shall be responsible for the ongoing coordination of supports and services included in the participant's plan of care.
Support coordinators assist participants who select to participate in the self-direction option with the following activities:
a. developing the participant's plan of care;
b. organizing the unique resources the participant needs;
c. training participants on their employer responsibilities;
d. completing required forms necessary for participation in Self-Direction;
e. back-up service planning;
f. budget planning;

g. verifying that potential employees meet program qualifications; and
h. ensuring participants' needs are being met through services.

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

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

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

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	Case Management

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Support Coordination

Provider Category:
Agency
Provider Type:
Case Management
Provider Qualifications

License *(specify)*:
Case Management Licensing Standards:

LAC 48:I. Chapter 49 4901-4981 LR Vol. 20 No. 8 August 20, 1994.

Certificate *(specify)*:
None

Other Standard *(specify)*:
Children's Choice Provider Manual published April 1, 2011
Providers must enroll as a Medicaid Case Management provider.

Louisiana identifies "Case Management" as "Support Coordination." Support Coordinators' qualifications are the same as case managers.

Support coordination agencies are required to perform the activities
• Intake,
• Assessment,
•Plan of Care Development and Implementation,
•Follow-Up/Monitoring,
•Reassessment, and
•Transition/Closure

Support Coordinator (SC) and Support Coordinator Supervisor (SCS) Qualifications: Must meet the following:

1). A Bachelor's or Master Degree in social work from a program accredited by the Council on

Social Work Education; or
2). A Bachelors' or Master Degree in nursing (RN) currently licensed in Louisiana (one year of paid experience will substitute for the degree); or
3). A Bachelor's or Master Degree in a human service field which includes; psychology, education, counseling, social services, sociology, philosophy, family and consumer sciences, criminal justice, rehab services, child development, substance abuse, gerontology, and vocational rehabilitation; or
4). A Bachelor's in liberal arts or general studies with a concentration of at least 16 hours in one of the fields listed in item 3 of this part.
(CMS) Qualifications add two years of paid post degree experience in providing case management services to numbers 1, 2, 3, and 4.

All training as identified and mandated by DHH is required in addition to the following:

Orientation and Training for New Employees
New Staff Orientation

• Orientation of at least sixteen (16) hours must be provided to all staff, volunteers, and students within five (5) working days of employment.

• A minimum of eight (8) hours of the orientation training must cover orientation to the target population including, but not limited to, specific service needs and resources.

• This orientation must include, at a minimum the following:
  o Support Coordination Provider policies and procedures.
  o Medicaid and other applicable DHH policies and procedures.
  o Confidentiality.
  o Documentation in case records.
  o Participant rights protection and reporting of violations.
  o Participant abuse and neglect reporting policies and procedures.
  o Recognizing and defining abuse and neglect.
  o Emergency and safety procedures.
  o Data management and record keeping.
  o Infection control and universal precautions.
  o Working with the target or waiver populations.
  o Professional ethics.
  o Outcome measures.

Training for New Staff:

• In addition to the required sixteen (16) hours of orientation, all new employees with no documented training must receive an additional minimum sixteen (16) hours of training during the first ninety (90) calendar days of employment.
• This training must be related to the target or waiver populations to be served and include specific knowledge, skills, and techniques necessary to provide case management to the target or waiver populations.
• This training must be provided by an individual with demonstrated knowledge of both the training topics and the target or waiver populations.

• This training must include at a minimum the following:
  o Assessment techniques.
  o Support and service planning.
  o Support and service planning for people with complex medical. needs, including information on bowel management, aspiration, decubitus, nutrition.
  o Resource identification.
  o Interviewing and interpersonal skills.
  o Data management and record keeping.
  o Communication skills.
  o Cultural awareness.
  o Personal outcome measures.

• A new employee may not be given Support Coordination responsibility until the orientation is satisfactorily completed.

NOTE: Routine supervision may not be considered training.

Annual Training:

• It is important for SC's to receive continuing training to maintain and improve skills. Each SC must satisfactorily complete forty (40) hours of Support Coordination related training annually which may include training updates on subjects covered in orientation and initial training. SC's annual training year begins with the date of hire.

• The sixteen (16) hours of training for new staff required in the first ninety (90) days of employment may be part of the forty (40) hour minimum annual training requirement. Appropriate updates of topics covered in orientation and training for a new case manager must be included in the required forty (40) hours of annual training.

• The following is a list of suggested additional topics for training:
o Nature of illness or disability, including symptoms and behavior
o Pharmacology
o Potential array of services for the population
o Building natural support systems
o Family dynamics
o Developmental life stages
o Crisis management
o First aid/CPR
o Signs and symptoms of mental illness, alcohol and drug addiction, mental retardation/developmental disabilities and head injuries
o Recognition of illegal substances
o Monitoring techniques
o Advocacy
o Behavior management techniques
o Values clarification/goals and objectives
o Available community resources
o Accessing special education services
o Cultural diversity
o Pregnancy and prenatal care
o Health management
o Team building/interagency collaboration.
o Transition/closure
o Age and condition-appropriate preventive health care.
o Facilitating team meetings
o Computers
o Stress and time management
o Legal issues
o Outcome measures
o Person-centered planning
o Self-determination or recipient-directed services

Training for Supervisors

• Each Support Coordination supervisor must complete a minimum of forty (40) hours of training a year. In addition to the required and suggested topics for case managers, the following are suggested topics for supervisory training:

o Professional identification/ethics
o Process for interviewing, screening, and hiring of staff
o Orientation/in service training of staff

o Evaluating staff
o Approaches to supervision
o Managing caseload size
o Conflict resolution
o Documentation
o Time management

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana 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:
Extended State Plan Service

Service Title:
Specialized Medical Equipment and Supplies

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):*
Specialized medical equipment and supplies are specified devices, controls, or appliances, specified in the plan of care, which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan.

Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the Medicaid State plan and shall exclude those items which are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. This service may

also be used for routine maintenance or repair of specialized equipment. Some examples would include sip and puffer switches, other specialized switches, voice activated, light activated, or motion activated devices to access the participant's environment. Routine maintenance or repair of specialized medical equipment is funded under this service.

To avoid delays in service provisions/implementation, the Support Coordinator's should be familiar with the process for obtaining Specialized Medical Equipment and Supplies or Durable Medical Equipment (DME) through the Medicaid State Plan.

Excluded are those specialized equipment and supplies that are not of direct medical or remedial benefit to the participant such as:
• Appliances (washer, dryer, stove, dishwasher, vacuum cleaner, etc.) swimming pool, hot tub, etc. eye exams, athletic and tennis shoes, automobiles, van lifts attached to van other than the participant's or the participant's family, adaptive toys, recreation equipment (swing set, etc.)
• Personal computers and software, daily hygiene products (deodorant, lotions, soap, toothbrush, toothpaste, feminine products, Band-Aids, q- tips, etc.)
• Rent subsidy, food, bed covers, pillows, sheets, etc. exercise equipment, taxi fares, Intra and Interstate transportation services bus passes, pagers including monthly service, telephones including mobile telephones and monthly service, Home Security Systems, including monthly service.

Excluded are those durable and non-durable items that are available under the Medicaid State Plan. Support Coordinator's shall pursue and document all alternate funding sources that are available to the participant before submitting a request for approval to purchase or lease specialized medical equipment and supplies.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
No limits on the amount/ frequency of services other than approved POC budget limit. Children's Choice is a capped waiver. Maximum amount of services provided cannot exceed annual waiver cap.

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	HCBS-Personal Care Attendant Module

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:
HCBS-Personal Care Attendant Module
Provider Qualifications
License *(specify)*:
Home and Community Based Services Provider Licensing Standards-LAC 48:1, Chapter 50; January 20, 2012
Certificate *(specify)*:

Other Standard *(specify):*
Must meet all applicable vendor standards and/or requirements for manufacturing, design and installation of technological equipment and supplies
Personal Care Attendant Agency verifies provider's qualification.

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana Department of Health and Hospitals (Health Standards Section)

Frequency of Verification:
Initially and 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:
Aquatic Therapy

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):*
Aquatic therapy uses the resistance of water to rehabilitate an individual with a chronic illness, poor or lack of muscle tone or a physical injury/disability. Aquatic Therapy assist in patient healing, exercise performance and muscle strengthening without the use of weights with decreased joint stress, decrease swelling and improve joint position awareness, decrease joint and soft tissue swelling following injury or arthritic disorders, spasms, back pain and fibromyalgia. Aquatic therapy is not for individuals who have fever, infections and are bowel/ bladder incontinent.

Individual with Disabilities Education Act (IDEA; 20 U.S.C. 1401 et seq.) services address educational needs of child in a school setting with adaptive educational programs specially designed for students with

disabilities. This waiver service differs as it addresses the therapeutic needs of a child which are designed to increase participant's independence, participation and productivity in the home and community. Services cannot be provided in a school setting.

All available Medicaid State Plan and IDEA services must be utilized before accessing this service. All services must be outlined on the Plan of Care to prevent duplication of services

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

No limits on the amount/ frequency of services other than approved POC budget limit. Children's Choice is a capped waiver. Maximum amount of services provided cannot exceed annual waiver cap of plan of care year

Requires Prior Authorization

Services cannot be provided same day at same time as any other waiver or state plan services.

Cannot be provided in school setting

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	Physical Therapy
Individual	Occupational Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Aquatic Therapy

Provider Category:

Individual

Provider Type:

Physical Therapy

Provider Qualifications

License *(specify):*

Physical Therapist- License Title

State Board of Examiners for Physical Therapy-LA R.S.37:2401-2421

Certificate *(specify):*

Aquatic Therapy Rehabilitation Industry Certified

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana State Board of Physical Therapy Examiners for the state license

Frequency of Verification:

Initially and annually for the state license, certification

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Aquatic Therapy

Provider Category:
Individual

Provider Type:
Occupational Therapist

Provider Qualifications

License *(specify):*
Occupational Therapist - License Title
LA State Board of Medical Examiners for State of Louisiana- LA R.S.37:3001-3014

Certificate *(specify):*
Aquatic Therapy Rehabilitation Industry Certified

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana State Board of Medical Examiners for the State of Louisiana for state license (Occupational Therapy)

Frequency of Verification:
Initially and annually for the state license, certification

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:
Art Therapy

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):*
Art therapy is used to increase awareness of self and others, cope with symptoms, stress and traumatic experiences; enhance cognitive abilities and as a mode of communication and enjoy the life–affirming pleasure of making art.
Art therapy is the therapeutic use of art by people who experience illness, trauma, emotional, behavioral or mental health problems, those who have learning or physical disabilities, life-limiting conditions, brain injuries or neurological conditions and/or challenges in living, and by people who strive to improve personal development.

Individual with Disabilities Education Act (IDEA; 20 U.S.C. 1401 et seq.) services address educational needs of child in a school setting with adaptive educational programs specially designed for students with disabilities. This waiver service differs as it addresses the therapeutic needs of a child which are designed to increase participant's independence, participation and productivity in the home and community. Services cannot be provided in a school setting.

All available Medicaid State Plan and IDEA services must be utilized before accessing this service. All services must be outlined on the Plan of Care to prevent duplication of services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
No limits on the amount/ frequency of services other than approved POC budget limit. Children's Choice is a capped waiver. Maximum amount of services provided cannot exceed annual waiver cap per plan of care year. Requires Prior Authorization.
Services cannot be provided same day at same time as any other waiver or state plan services.
Cannot be provided in school setting.

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	Physical Therapy
Individual	Occupational Therapy

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Art Therapy

Provider Category:
Individual
Provider Type:
Physical Therapy
Provider Qualifications
License *(specify):*
Physical Therapist - License Title
State Board of Examiners for Physical Therapy-LA R.S.37:2401-2421

Certificate *(specify):*
Certified/Registered Art Therapists (professionals trained in both art and therapy) who have received and maintained board Certification from Art Therapy Credentials Board, Inc.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
State Board of Examiners for Physical Therapy
Frequency of Verification:
Initially and annually for the state license, certification

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Art Therapy

Provider Category:
Individual
Provider Type:
Occupational Therapy
Provider Qualifications
License *(specify):*
Occupational Therapist - License Title
LA State Board of Medical Examiners for State of Louisiana- LA R.S.37:3001-3014
Certificate *(specify):*
Certified/ Registered Art Therapist-Board Certification from the Art Therapy Credentials Board, inc.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Louisiana State Board of Medical Examiners for the State of Louisiana- for state license Occupational Therapy)
Frequency of Verification:
Initially and annually for the state license, certification

Appendix C: Participant Services

C-1/C-3: Service Specification

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

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):*
Environmental accessibility adaptations are physical adaptations to the home or vehicle. They are provided when required by the participant's Plan of Care, as necessary to assure the health, welfare and safety of the participant or which enable the participant to function with greater independence without which the participant would require additional supports or institutionalization.
• Adaptations to the home may include the installations of ramps and/or grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.
• An example of adaptation to the vehicle is a van lift, or other adaptations to make the vehicle accessible to the participant.
• Environmental adaptations must be provided by an individual/agency deemed capable by the participant's family. All providers must meet any applicable state or local requirements for licensure or certification, (such as building contractors, plumbers, electricians, or engineers). When state and local building or housing code standards are applicable, modifications to the home shall meet such standards.
• Adaptations which add to the total square footage of the home are excluded from this benefit.
• Excluded are those adaptations or improvements to the home or vehicle that are of general utility, and are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning, a fence, etc.
• Home modification funds are not intended to cover basic construction cost. For example, in a new home, a bathroom is already part of the building cost. Waiver funds can be used to cover the difference between constructing a bathroom and building an accessible or modified bathroom.
• Fire alarms, smoke detectors, and fire extinguishers are not considered environmental adaptations and are excluded.
• Excluded is the purchase or lease of a vehicle and regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

Any services covered by Title XIX (Medicaid State Plan Services) are excluded.
Any services denied by Title XIX (Medicaid State Plan Services) are not reimbursable.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
No limits on the amount/ frequency of services other than approved POC budget limit. Children's Choice is a capped waiver. Maximum amount of services provided cannot exceed annual waiver cap per plan of care year.

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	HCBS Personal Care Attendant Module

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Agency

Provider Type:
HCBS Personal Care Attendant Module

Provider Qualifications

License *(specify):*
Home and Community Based Services Provider Licensing Standards-LAC 48:1, Chapter 50; January 20, 2012

Certificate *(specify):*
N/A

Other Standard *(specify):*
Environmental Modification providers must meet all applicable state and /or local (City or Parish) requirement (i.e., building contractors, plumbers, electricians, or engineers).

All environmental accessibility adaptation providers must be registered through the Louisiana State Licensing Board for Contractors as a home improvement contractor, with the exception of providers of vehicle adaptation. When required by state law, the person performing the services such as building contractors, plumbers, electrician, or engineers must meet applicable requirements for professional licensure and modification the home and all applicable building code standards.

Providers of environmental accessibility adaptation to vehicles must be licensed by the Louisiana Motor Vehicle Commission as a specialty vehicle dealer and accredited by the National Mobility Equipment Dealers Association under the Structural Vehicle Modifier category.

Personal Care Attendant Agency verifies provider's qualification.

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana 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:

Family Support 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):*

Family supports services (Personal Care Attendant Services) are services provided directly to the participant which enables a family to keep the participant or family member with a developmental disability, Autism and/or Mental Retardation at home which also enhances family functioning. Services may be provided in the participant's home or outside the participant's home in such settings as after school programs, summer camps, or other places specified in the approved plan of care. Family support includes assistance with participating in the community, including activities to maintain and strengthen existing informal networks and natural supports. Providing transportation to these activities is also included.

Family Supports services caregivers may be members of the participant's family. The following individuals shall not be employed or contracted by the waiver services provider to provide services reimbursed through Children's Choice: 1) legally responsible relatives (spouses, parents or stepparents, foster parents, or legal guardians); or 2) any other relatives who live in the same household with the waiver participant. Family members who provide family support services must meet the same standards as caregivers who are unrelated to the participant.

Supervision of individuals providing family support services shall be furnished by the licensed personal care agency as required by state licensing requirements. Frequency or intensity of supervision shall be provided as required by state licensing regulations.

Family Support Services require prior authorization from OCDD. Family Support Services are provided as a distinct and separate service in the Children's Choice Waiver and are not provided under the approved Medicaid State Plan. The Children's Choice Family Support Services are provided by a Personal Care Attendant (PCA). PCA services are separate and apart from the EPSDT Personal Care Services (PCS).

Children's Choice PCA is described below:

- Can be provided without family present for all approved waiver participants;
- Must be prior authorized by OCDD;
- Must be in an approved Plan of Care completed by the support coordinator;
- May transport or accompany participant to medical appointments and other community outings as approved in the Plan of Care.
- May administer medication as per HCBS DSW rules and policy.

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

No limits on the amount/ frequency of services other than approved POC budget limit. Children's Choice is a capped waiver. Maximum amount of services provided cannot exceed annual waiver cap per plan of care year.

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	Direct Service Worker
Agency	HCBS Personal Care Attendant Module

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Support Services

Provider Category:
Agency
Provider Type:
Direct Service Worker
Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Direct service workers under the Self-Direction option must enroll as providers directly with Medicaid using the Medicaid Provider Agreement (PE-50). The following individual qualifications are also required of direct service workers under the Self-Direction option:
1. Be at least 18 years of age.
2. Have a high school diploma, GED, trade school diploma, demonstrated competency, or verifiable work experience in providing support to persons with disabilities.
3. Pass a criminal history background check.
4. Possess a valid social security number.
5. Have certification in First Aid and CPR as approved by the American Heart Association or the American Red Cross.

Additionally, direct service workers must be able to complete the tasks indicated on the participant's plan of care. This training may be provided by the family or through a training facility. Documentation, signed by the participant/authorized representative and support coordinator, which indicates the worker is able to complete the tasks indicated on the participant's plan of care must be submitted to the fiscal agent before the employee can be hired. All training documentation must be kept in the participant's home book for monitoring and review by the support coordinator during the quarterly home visits.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal/Employer Agent
Frequency of Verification:

Initially and on-going

The fiscal agent is responsible to verify that direct support workers have met qualifications. The fiscal agent at the respective 1 and 3 year intervals based on the type of training needing re-certification will notify each direct support worker and the Self-Direction Program Manager. The fiscal agent will update their file with documentation of training as each required re-certification is completed. The fiscal agent will continue to notify the Self-Direction Program Manager for monitoring purposes until all required re-certifications are completed.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Support Services

Provider Category:
Agency

Provider Type:
HCBS Personal Care Attendant Module

Provider Qualifications

License *(specify):*
Home and Community Based Services Provider Licensing Standards-LAC 48:1, Chapter 50; January 20, 2012

Certificate *(specify):*
N/A

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana 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:
Family Training

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)*:
Family Training consists of training and education for the families of participants (payment for participant is excluded) served by Louisiana Children's Choice Waiver. This training and education must be conducted by professional organizations or practitioners who offer education or training appropriate to the needs of the participant. It must be individually approved by Local Governing Entity, and incorporated in the approved plan of care. For purposes of this service only, "family" is defined as unpaid persons who live with or provide care to a participant served by the Louisiana Children's Choice Waiver and may include a parent, spouse, children, relatives, foster family, legal guardian, or in-laws.

Training and education includes payment that is available for registration and training fees associated with formal instruction in areas relevant to the participant needs identified in the plan of care. Payment is not available for the costs of travel, meals and overnight lodging to attend a training event or conference.

Individual with Disabilities Education Act (IDEA; 20 U.S.C. 1401 et seq.) services address educational needs of a child in a school setting with adaptive educational programs specially designed for students with disabilities. Family Training for a family member cannot be provided in a school setting.

All available Medicaid State Plan and IDEA services must be utilized before accessing Family Training. All services must be outlined on the Plan of Care to prevent duplication of services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
N/A

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	HCBS Personal Care Attendant Module

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Training

Provider Category:
Agency
Provider Type:
HCBS Personal Care Attendant Module
Provider Qualifications
License *(specify):*
Home and Community Based Services Provider Licensing Standards-LAC 48:1, Chapter 50; January 20, 2012
Certificate *(specify):*
N/A
Other Standard *(specify):*
National organization for specific conditions; State or local organization recognized as an expert in specific conditions or care modalities;
Training must be provided by national organization or disease specific organization that is certified and accredited. Documentation of requested training description, pamphlets, and course objective as well as trainers qualification are reviewed prior to approval.
Verification of Provider Qualifications
Entity Responsible for Verification:
Louisiana 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:
Hippotherapy/Therapeutic Horseback Riding

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):*
Hippotherapy/Therapeutic Horseback Riding is used to promote the use of the movement of the horse as a treatment strategy in physical, occupational and speech-language therapy sessions for people living with disabilities. The movement of the horse provides physical and sensory input which is variable, rhythmic and repetitive. Equine movement coerces the client to use muscles and body systems in response to movement of the horse. Hippotherapy improves muscle tone, balance, posture, coordination, motor development as well as motor planning that can be used to improve sensory integration skills and attention skills. Equine movement can be used to facilitate the neurophysiologic systems that support all functional daily living skill. The client passively responds to and interacts with the horse's movement making it purely the horse's movement that influences the client's response. Specially trained therapy professional evaluate each potential participant on an individual basis to determine the appropriateness of including Hippotherapy as a treatment strategy.

Therapeutic Horseback Riding teaches riding skills in addition to improving muscle tone, balance, posture coordination and motor development. Specially trained therapy professional evaluate each potential patient on an individual basis to determine the appropriateness of including Therapeutic Horseback riding as a treatment strategy.

Hippotherapy requires therapy session that are one on one with Licensed Physical Therapist, Licensed Speech Therapist and/or Licensed Occupational Therapist who work closely with the horse professional in developing treatment strategies. Licensed therapist must be present during therapy sessions.

Therapeutic horseback riding therapy sessions does not required the licensed therapist to be present during sessions and may be completed one on one or in groups up to 4 per sessions. Therapeutic horseback riding treatment strategies must be directed by Licensed Physical Therapist, Licensed Speech Therapist and/or Licensed Occupational Therapist.

Hippotherapy and Therapeutic Horseback Riding must be ordered by a Physician with implementation of service, treatment strategies and goals developed by Licensed Therapist. Services must be included in participant's plan of care.

Individual with Disabilities Education Act (IDEA; 20 U.S.C. 1401 et seq.) services address educational needs of child in a school setting with adaptive educational programs specially designed for students with disabilities. This waiver service differs as it addresses the therapeutic needs of a child which are designed to increase participant's independence, participation and productivity in the home and community. Services cannot be provided in a school setting.

All available Medicaid State Plan and IDEA services must be utilized before accessing this service. All services must be outlined on the Plan of Care to prevent duplication of services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
No limits on the amount/ frequency of services other than approved POC budget limit. Children's Choice is a capped waiver. Maximum amount of services provided cannot exceed annual waiver cap per plan of care year.
Requires Prior Authorization
Services cannot be provided same day at same time as any other waiver or state plan services. Services cannot be provided in school setting.

Medicaid will pay for hippotherapy only if a licensed physical therapist, licensed occupational therapist and/or licensed speech therapist is present.

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	Occupational Therapist
Individual	Physical Therapy
Individual	Speech Therapy

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Hippotherapy/Therapeutic Horseback Riding

Provider Category:
Individual

Provider Type:
Occupational Therapist

Provider Qualifications

License *(specify):*
Occupational Therapist - License Title
LA State Board of Medical Examiners for State of Louisiana- LA R.S.37:3001-3014

Certificate *(specify):*
Occupational Therapist certified in hippotherapy/Therapeutic horseback riding using it as a treatment modality.

Other Standard *(specify):*
Occupational Therapist who work closely with the horse professional to manipulate various aspects of the horse's movement, position, management styles, equipment and types of activities to generate effective remediation protocols and to promote functional outcomes.

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana State Board of Medical Examiners for the State of Louisiana for state license Occupational Therapy)

Frequency of Verification:
Initially and annually for the state license, certification

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Hippotherapy/Therapeutic Horseback Riding

Provider Category:
Individual

Provider Type:
Physical Therapy

Provider Qualifications

License *(specify):*
Physical Therapist - License Title
State Board of Examiners for Physical Therapy-LA R.S.37:2401-2421

Certificate *(specify):*
Physical Therapist certified in hippotherapy/Therapeutic horseback riding using it as a treatment modality.

Other Standard *(specify):*
Physical Therapist who work closely with the horse professional to manipulate various aspects of the horse's movement, position, management styles, equipment and types of activities to generate effective remediation protocols and to promote functional outcomes

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana State Board of Physical Therapy Examiners for the state license

Frequency of Verification:
Initially and annually for the state license, certification

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Hippotherapy/Therapeutic Horseback Riding

Provider Category:
Individual

Provider Type:
Speech Therapy

Provider Qualifications

License *(specify):*
Speech Therapist - License Title
Examiners of Speech and Language Pathology and Audiology La R.S.37:2650-2666

Certificate *(specify):*
Speech Therapist certified in hippo therapy/Therapeutic horseback riding using it as a treatment modality.

Other Standard *(specify):*
Speech Therapist who work closely with the horse professional to manipulate various aspects of the horse's movement, position, management styles, equipment and types of activities to generate effective remediation protocols and to promote functional outcomes

Verification of Provider Qualifications

Entity Responsible for Verification:
Examiners of Speech and Language Pathology and Audiology- for the state license

Frequency of Verification:
Initially and annually for the state license, certification

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 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 Service enables waiver participants to maintain their own housing as set forth in the participant's approved plan of care (POC). Services must be provided in the home or a community setting. The service includes the following components:

1. 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. Participate in plan of care renewal and updates as needed.
5. Provide supports and interventions per the individualized housing stabilization service provider plan. If additional supports or services are identified as needed outside the scope of Housing Stabilization Services, communicate the needs to the Support Coordinator.
6. Communicate with the landlord or property manager regarding the participant's disability, accommodations needed, and components of emergency procedures involving the landlord or property manager.
7. If at any time the participant's housing is placed at risk (eg.,eviction, loss of roommate or income), Housing Stabilization Services will provide supports to retain housing or locate and secure housing to continue community based supports including locating new housing, sources of income, etc.

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 Transition 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 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:
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 enable 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:
Music Therapy

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):*
Music Therapy is used to promote wellness, manage stress, alleviate pain, express feelings, enhance memory, improve communication and promote physical rehabilitation. Individuals who benefit from music therapy include children and adolescents with mental health needs, developmental and learning disabilities, brain injuries, physical disabilities and acute and chronic pain. Music Therapy can be part of a stress management program or used in conjunction with exercise and is used in a variety of health care settings. Music therapies help clients improve their cognitive functioning, motor skills, emotional and affective development, behavior and social skills and quality of life. Music therapy assists special learners to strengthen non-musical areas such as communication skills and physical coordination skills which are important for daily life.

Individual with Disabilities Education Act (IDEA; 20 U.S.C. 1401 et seq.) services address educational needs of child in a school setting with adaptive educational programs specially designed for students with disabilities. This waiver service differs as it addresses the therapeutic needs of a child which are designed to increase participant's independence, participation and productivity in the home and community. Services cannot be provided in a school setting.

All available Medicaid State Plan and IDEA services must be utilized before accessing this service. All services must be outlined on the Plan of Care to prevent duplication of services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
No limits on the amount/ frequency of services other than approved POC budget limit. Children's Choice is a capped waiver. Maximum amount of services provided cannot exceed annual waiver cap per plan of care year. Requires Prior Authorization
Services cannot be provided same day at same time as any other waiver or state plan services. Services cannot be provided in school setting.

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	Physical Therapy
Individual	Music Therapist
Individual	Occupational Therapy

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Music Therapy

Provider Category:
Individual

Provider Type:
Physical Therapy

Provider Qualifications

License *(specify):*
Physical Therapist - License Title
State Board of Examiners for Physical Therapy-LA R.S.37:2401-2421

Certificate *(specify):*
Board Certified Music Therapist

Other Standard *(specify):*
Music Therapist-Board Certified- the National Music Therapy Registry serves qualified music therapy professional with the following designations RMT, CMT, ACMT. These individuals have met accepted education and clinical training standard and are qualified to practice music therapy-Credentialed professional who has completed an approved music therapy program.

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana State Board of Physical Therapy Examiners for the state license

Frequency of Verification:
Initially and annually for the state license, certification

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Music Therapy

Provider Category:
Individual

Provider Type:
Music Therapist

Provider Qualifications

License *(specify):*
Board Certified Music Therapist (MT-BC)

Certificate *(specify):*
Board Certified Music Therapist (MT-BC)

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
The Certification Board for Music Therapist - CBMT

Frequency of Verification:
Must be recertified every five (5) years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Music Therapy

Provider Category:

Individual

Provider Type:
Occupational Therapy
Provider Qualifications
License *(specify):*
Occupational Therapist - License Title
LA State Board of Medical Examiners for State of Louisiana- LA R.S.37:3001-3014
Certificate *(specify):*
Music Therapist- Board Certified- The National Music Therapy Registry
Other Standard *(specify):*
Music Therapist-Board Certified- the National Music Therapy Registry serves qualified music therapy professional with the following designations RMT, CMT, ACMT. These individuals have met accepted education and clinical training standard and are qualified to practice music therapy- Credentialed professional who has completed an approved music therapy program.
Verification of Provider Qualifications
Entity Responsible for Verification:
Louisiana State Board of Medical Examiners for the State of Louisiana- for state license Occupational Therapy)
Frequency of Verification:
Initially and annually for the state license, certification

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:
Sensory Integration

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):*

Sensory Integration is used to improve the way the brain processes and adapts to sensory information, as opposed to teaching specific skills. Sensory Integration involves activities that provide vestibular, proprioceptive and tactile stimuli which are selected to match specific sensory processing deficits of the participant. Proposed use as a treatment of developmental disorders where there is an established dysfunction of sensory processing, for example: children with autism, attention deficit hyperactivity disorder (ADHD), brain injuries, fetal alcohol syndrome, neurotransmitter diseases, etc. Activities provided are based on reliable evidence and not experimental.

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

No limits on the amount/ frequency of services other than approved POC budget limit. Children's Choice is a capped waiver. Maximum amount of services provided cannot exceed annual waiver cap per plan of care year. Requires Prior Authorization

Services cannot be provided same day at same time as any other waiver or state plan services. Services cannot be provided in school setting.

Services may be provided in the home, clinical settings, and/or community.

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	Physical Therapy
Individual	Occupational Therapy

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Sensory Integration

Provider Category:

Individual

Provider Type:

Physical Therapy

Provider Qualifications

License *(specify)*:

Physical Therapist - License Title

State Board of Examiners for Physical Therapy-LA R.S.37:2401-2421

Certificate *(specify)*:

Physical Therapist certified in Sensory Integration Therapy

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana State Board of Physical Therapy Examiners for the state license

Frequency of Verification:

Initially and annually for the state license, certification

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Sensory Integration

Provider Category:
Individual

Provider Type:
Occupational Therapy

Provider Qualifications

License *(specify):*
Occupational Therapist - License Title
LA State Board of Medical Examiners for State of Louisiana- LA R.S.37:3001-3014

Certificate *(specify):*
Occupational Therapist certified in Sensory Integration Therapy

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana State Board of Medical Examiners for the State of Louisiana for state license Occupational Therapy)

Frequency of Verification:
Initially and annually for the state license, certification

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, January 20, 2012 and Louisiana R.S. 40:1300.52 and 40:1300.53, 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.
• 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 offenses).

• 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 on all unlicensed persons providing direct care and services to clients.
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.

• The Fiscal Agent is also responsible for assuring that criminal background checks are conducted on each self- directed DSW.

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

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

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

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings

have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The state maintains a registry that includes the names of all direct service workers that 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 to assure that no existing workers have had a finding placed against them.
-The Louisiana Department of Health, Health Standards Section has a contractor that maintains the Direct Service Worker Abuse Registry for the state. Health Standards Program Manager 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 December 20, 2012 in the Louisiana Register Vol. 38, number 12.
-On each survey conducted at a provider agency a sample of employee personnel files are pulled. Those files will be reviewed for compliance with any screenings that are required by the regulations. If the provider is found 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 Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

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

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

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

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

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

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

- (●) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

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

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

- ( ) **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 Licensed HCBS providers can access information on becoming an enrolled waiver service provider several ways:
  o. Via the Louisiana Medicaid website;
  o. Through state facilitated stakeholder meetings regarding waiver services; and
  o. 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 had a problem 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:
  o. 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 Louisiana Department of Health, Health Standards Section (HSS);
  o. BHSF/HSS trains all DD waiver providers in licensing and certification procedures and requirements;
  o. 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;
  o. BHSF, or its designee, reviews all information, and makes a determination whether to enroll the provider in the Medicaid program;
  o. BHSF, or its designee, assigns each new enrolled provider a unique Medicaid provider number and sends the OCDD/HSS this information;
  o. The provider's name is then added to the Freedom of Choice list;
  o. 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;
  o. 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
  o. 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 fifteen (15 working days from receipt of a completed enrollment application form.

Once the licensing process is completed, the enrollment process proceeds.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
C.a.i.a.1. Number and percentage of initial providers who obtained licensure/certification in accordance with state law/policy prior to service provisions. Numerator = number of initial providers who obtained licensure/certification prior to service provisions; Denominator = Total number of initial providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Aspen Central Office (ACO)Data Base

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 substantiated licensing complaints. Numerator = number of substantiated licensing complaints; Denominator = the total number of complaints

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
C.a.i.a.3. Number and percentage of provider's who conducted background checks on direct services workers in accordance with state laws/policies. Numerator = Number of providers who conducted background checks on direct services workers in accordance with state laws/policies; Denominator = Total number of providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
ACO 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 =
☐ 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):*

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

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

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

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

☑ **Other** Specify: fiscal/employer agent	☐ **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: fiscal/employer agent	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C.a.i.b.2. Number and percentage of self-direction employees screened by the fiscal/employer agent who are eligible for hire due to passing a criminal background screening. Numerator = Number of newly hired self-direction employees who pass the initial background screening; Denominator = Total number of newly hired self-direction employees.

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

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

☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: fiscal/employer agent	☐ **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: fiscal/employer agent	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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

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

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

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

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):*

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.

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 Measure C.a.i.a.1, C.a.i.a.2, C.a.i.a.3: 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 Medicaid reimbursements.

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.

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

C.a.i.b.1 and C.a.i.c.1 Quarterly, OCDD reviews at least 4 random reports to insure a licensed/ non certified individual are eligible for hire due to passing the background check and continue to meet training requirements. If it is determined that an individual did not meet requirements initially or does not continues to meet requirements, the fiscal agent is contacted to immediately notify employer and terminate employee. Fiscal Agent will remove the employee from payroll and insure edits are in place to prevent any future payments.

ii. **Remediation Data Aggregation**

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings 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.

The settings are not in fully compliance at this time. Please refer to Attachment #2.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Comprehensive Plan of Care (CPOC)

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: