Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

The Louisiana Department of Health, Bureau of Health Services Financing, Medicaid Eligibility Determination Regional Office, informs individuals and/or their authorized representatives of the "feasible alternatives" under the waiver. When the waiver offer is made, the LGE ensures that the individuals and/or their authorized representatives and are given the choice of either institutional or home and community-based services. The LGE currently utilizes the "Case Management Choice and Release of Information Form" to allow the person to state that they understand their choices and the alternatives under the waiver. The information is reviewed with the participant and/or authorized representative at a pre-certification home visit prior to approval of the initial plan of care and annually thereafter.

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

The forms are maintained in the records at the LGE and the physical office of the Support Coordination Agency.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The Louisiana Department of Health has a Medicaid Eligibility Supports Section to assist individuals who have language barriers. When the LGE identifies an individual who needs language assistance, the request is submitted to the MPSW Section who reviews and forwards the request to the Eligibility Supports Section to assist the individual. A contracted interpreter is utilized to assist the individual. All 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	Day Habilitation
Statutory Service	Individual and Family Support
Statutory Service	Prevocational Services
Statutory Service	Supported Independent Living
Statutory Service	Supported Employment
Extended State Plan Service	Skilled Nursing
Extended State Plan Service	Specialized Medical Equipment and Supplies

Service Type	Service
Other Service	Adult Companion Care
Other Service	Community Integration and Development
Other Service	Environmental Accessibility Adaptations
Other Service	Housing Stabilization Service
Other Service	Housing Stabilization Transition Service
Other Service	One-Time Transitional
Other Service	Personal Emergency Response
Other Service	Professional Services
Other Service	Substitute Family Care (SFC)

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Supports and services provided for relief of those persons normally providing unpaid care to individuals unable to care for themselves, furnished on a short term basis, by a licensed respite facility. These services are necessary to keep individuals from being institutionalized. Individual and family support services cannot be

provided while an individual is in a center based respite care setting.

Federal Financial Participation (FFP) will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in a Licensed respite care facility, with the availability of community outings. Community outings would included on the approved POC and would include activities such as school attendance, or other school activities, or other activities the individual would receive if they were not in the center-based respite facility. Transportation to and from these activities are included in the rate for center-based respite. Community outings would provide the individual's routine to continue without interruption. Individual and Family Support services will not be reimbursed while the participant is in a center-based respite facility.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limited to 720 hours per recipient, per plan of care year. Process for approving hours in excess of 720 hours must go through State Office approval with proper justification and documentation.

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	Agency-Center-Based Respite

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:
Agency-Center-Based Respite
Provider Qualifications
License *(specify)*:
Home and Community Based Services Provider Licensing Standard LAC Title 48, Part I, Subpart 3, Chapter 50, Center Based Respite Module
Certificate *(specify)*:
Other Standard *(specify)*:
Verification of Provider Qualifications
Entity Responsible for Verification:
Louisiana Department of Health, Office of Management and Finance, 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:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope)*:

Day habilitation should focus on the person centered planning process, which would allow the participant a choice in how they spend their day. Day habilitation activities should assist the participant to gain their desired community living experience, including the acquisition, retention or improvement in self-help, socialization and adaptive skills, and/or to provide the individual an opportunity to contribute to his or her community. Day Habilitation is furnished in a variety of community settings, (i.e. local recreation department, garden clubs, libraries) other than the person's residence and is not limited to a fixed- site facility.

Day Habilitation Services may be coordinated with needed therapies in the individual's person-centered Plan of Care.

Career planning activities may be a component of the participant's plan and may be used to develop learning opportunities and career options consistent with the person's skills and interests.

Transportation services are offered and billable as a component of Day Habilitation. Transportation may be

provided to and/or from the participant's residence or a location agreed upon by the participant or authorized representative.

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

Day Habilitation is provided on a regularly scheduled basis and may be scheduled on a Plan of Care for 1 or more days per week and may be prior authorized for up to 8320 units of service in a plan of care year. A standard unit of service is a 15 minute increment.

Participants receiving Day Habilitation Services may also receive Prevocational or Supported Employment services, but these services cannot be provided during the same time period.

Day Habilitation transportation services may be billed for transporting a participant to or from the service. There is a maximum fee per day that may be billed for transportation, regardless of the number of trips per day.

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	Adult Day Habilitation

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Adult Day Habilitation

Provider Qualifications

License *(specify)*:

Home and Community Based Services Provider Licensing Standard LAC Title 48, Part I, Subpart 3, Chapter 50, Adult Day Care Module

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Department of Health, Office of Management and Finance, 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:

Personal Care

Alternate Service Title (if any):

Individual and Family Support

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:

Individual and Family Support (IFS) is direct support and assistance for a participant or for the relief of the caregiver, provided in or out of the participant's home to achieve and/or maintain the outcomes of increased independence, productivity, and inclusion in the community as outlined in the participant's POC and to enhance family functioning.

IFS services may be provided in the participant's home or outside the home to allow the participant to achieve and/or maintain increased independence, productivity, enhanced family functioning and inclusion in the community or for the relief of the primary caregiver. IFS services will not be provided in licensed respite care facilities and the provider may not bill for IFS services for the same time on the same day as respite services.

Up to three waiver participants who may or may not live together and who have a common direct service provider agency may share IFS staff when agreed to by all participants and their health and welfare can be assured. Shared IFS services may be either day or night services.

IFS-Night services are the availability of direct support and assistance provided while the participant is asleep and there is a reduced frequency and intensity of required assistance. IFS-Night services are not limited to traditional nighttime hours. Participants who are able to demonstrate their ability to notify direct support

workers during sleeping hours of their need for assistance may opt for IFS-Night service where staff do not remain awake. The participant's support team will assess the participant's ability to awaken staff. If it is determined that the participant is able to awaken staff and requests the IFS-Night services, the POC shall reflect this service. Support teams shall consider the use of technological devices that would enable notification/awakening of night staff. (Examples of devices include wireless pagers, monitoring systems that work from one room to another, a buzzer or bell, etc.).

Any change in participant's ability to notify night staff must be discussed by the support team. POC revisions will be made to reflect the need for staff to be awake. This change could be a result of medication, medical or other changes resulting in the inability of the participant to awaken night staff.

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

IFS-Day (IFS-D) services will be authorized during waking hours for up to 16 hours when natural supports are unavailable in order to provide continuity of services to the participant. Waking hours are the period of time when the participant is awake and not limited to traditional daytime hours. Additional hours of IFS day services beyond the 16 hours can be approved based on documented need, which can include medical or behavioral and specified in the POC.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Care Attendant
Individual	Direct Service Worker

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Individual and Family Support

Provider Category:

Agency

Provider Type:

Personal Care Attendant

Provider Qualifications

License *(specify)*:

Home and Community Based Services Provider Licensing Standard LAC Title 48, Part I, Subpart 3, Chapter 50 Personal Care Attendant Module

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Department of Health, Office of Management and Finance, Health Standards Section

Frequency of Verification:
Initally, annually, and as necessary

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Individual and Family Support

Provider Category:
Individual
Provider Type:
Direct Service Worker
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Home and Community Based Services Provider Licensing Standard LAC Title 48, Part I, Subpart 3, Chapter 92, Direct Service Worker Registry

OCDD Self Direction Handbook

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 will monitor training expiration and notify the participant/authorized representative of training due. 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 participant/authorized representative and the NOW Self-Direction Program Manager for monitoring purposes until all required re-certifications are completed.

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:
Prevocational Services
Alternate Service Title (if any):

HCBS Taxonomy:

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

Category 2: **Sub-Category 2:**

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Participants receiving prevocational services MUST have an employment related goal as part of their Plan of Care (POC) and service plan. The general habilitation activities must support their employment goals. Prevocational Services are designed to create a path to integrated community based employment for which an individual is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Prevocational services are intended to prepare a participant for paid employment or volunteer opportunities in the community to the participant's highest level. Prevocational services are where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Prevocational services are intended to develop and teach general skills such as ability to communicate effectively with supervisors, co-workers, and customers; accepted community workplace conduct and dress; ability to follow directions and attend to tasks; workplace problem solving skills and general workplace safety and mobility training. Prevocational Services are to be provided in a variety of locations in the community and are not to be limited to a fixed site facility.
Assistance with personal care may be a component of prevocational services, but may not comprise the entirety of the service.
Prevocational services are provided on a regularly scheduled basis and may be scheduled on a Plan of Care for 1 or more days per week and may be prior authorized for up to 8320 units of service in a plan of care year with appropriate documentation. A standard unit is 1/4 hour. Post authorization may be approved upon verification of services rendered.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Cannot exceed 8,320 ¼ hour units per participant per POC year.
•Limited to 8 hours a day, 5 days a week.
Cannot be provided or billed for during the same hours on the same day as; Day Habilitation, Supported Employment Models (one-to-one, follow along, mobile work crew/enclave), Professional Services, Professional Consultation, Transitional Professional Support Services, Individualized and Family Support – Day and Night, Shared Supports – Day and Night, Community Integration Development, or Center-Based Respite.

Prevocational services are expected to last no longer than 4 years with employment at the individual's highest level of work in the most integrated setting, with the job matched to the individual's interests, strengths, priorities, abilities and capabilities, while following applicable federal wage guidelines.

Prevocational services are services not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16)and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 71).

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	Pre-Vocational Habilitation

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency

Provider Type:
Pre-Vocational Habilitation

Provider Qualifications

License *(specify)*:
Home and Community Based Services Provider Licensing Standard LAC Title 48, Part I, Subpart 3, Chapter 50, Adult Day Care Module

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana Department of Health, Office of Management and Finance, 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:
Residential Habilitation

Alternate Service Title (if any):

Supported Independent Living

HCBS Taxonomy:

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

Category 2: **Sub-Category 2:**

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
This service is designed to provide support to participants who have limited natural supports and have an assessed need for assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payment for Supported Independent Living is not made for cost of room and board, the cost of home maintenance, upkeep and improvement, modifications or adaptations to a home, or to meet the requirements of the applicable life safety code. Payment for Supported Independent Living does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family for activities or supervision for which a payment is made by a source other than Medicaid.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Services are not reimbursed when the waiver participant is in a Center-Based Respite facility.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Supervised Independent Living

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Independent Living

Provider Category:
Agency

Provider Type:
Supervised Independent Living

Provider Qualifications

License *(specify):*
Home and Community Based Services Provider Licensing Standard LAC Title 48, Part I, Subpart 3, Chapter 50, Supported Independent Living Module

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana Department of Health, Office of Management and Finance, 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:
Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

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

Category 2: **Sub-Category 2:**

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Supported employment is competitive work, for participants who are 18 or older, in an integrated work setting in which the participants are working toward competitive work, consistent with strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of participants. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community–based employment for which an individual is compensated at or above minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.
These are services provided to participants who are not served by Louisiana Rehabilitation Services and need more intense, long term follow along and usually cannot be competitively employed because supports cannot be successfully phased out.

Supported employment models are:
1. Individual placement or one-to-one model: A one-to-one model is a placement strategy in which an employment specialist (job coach) places a participant into competitive employment, provides training and support, and then gradually reduces time and assistance at the worksite. The participant may then be transitioned to the Follow Along model of Supported Employment. A participant can move from the Follow Along model back to the one-to-one intensive model if the job changes or a new job has been secured for the participant and new tasks have to be learned.
2. Follow Along services are designed for persons only requiring minimum oversight to maintain the participant at the job site. Ongoing support services can be provided from more than one source.
3. Mobile Work Crew/Enclave is an employment setting in which a group of two or more participants, but fewer than eight perform work in a variety of locations under the supervision of a permanent employment specialist (job coach/supervisor). SE group must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation provided for the participant to the site of the supported employment model, or between the day habilitation and supported employment model site (if the participant receives services in more than one place) is reimbursable when Supported Employment services have been provided.
The NOW reimburses two separate per diem rates for transportation when Day Habilitation and/or Supported Employment services have been provided to the participant. One rate covers regular transportation and the other rate covers wheelchair transportation. There is a maximum fee per day that may be charged for transportation, regardless of the number of trips made per day.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service Exclusions:
1. Services shall not be used in conjunction or simultaneously with any other waiver service, except substitute family care, supported independent living, and skilled nursing services.

2. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by participants

receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

3. Services are not available to participants who are eligible to participate in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act, 20 U.S.C. 1401(16) and (71). Documentation which shows the participant is not eligible to participate in programs funded under the Rehabilitation Act and IDEA must be included in the participant's file prior to the participant receiving Medicaid waiver-funded supported employment services to prevent any duplication.

Service Limits:
1. One-to-One intensive services shall not exceed 1,280 1/4 hour units per POC year. Services shall be limited to eight hours a day, five days a week, for six to eight weeks.

2. Follow along services shall not exceed 24 days per POC year.

3. Mobile Crew/Enclave services shall not exceed 8,320 1/4 hour units of service per POC year, without additional documentation. This is eight hours per day, five days per week 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	Supported Employment

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
Supported Employment
Provider Qualifications
License *(specify)*:
Home and Community Based Services Provider Licensing Standard LAC Title 48, Part I, Subpart 3, Chapter 50, Supported Employment Module or certificate as listed below.
Certificate *(specify)*:
Louisiana Rehabilitation Services: Compliance Certificate signed by vendor and LRS Regional Manager or designee for the Community Rehabilitation Program or license as listed above.
Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Louisiana Department of Health, Office of Management and Finance, Health Standards Section for licensed providers.

Louisiana Department of Health Office for Citizens of Developmental Disabilities obtains annual list of CRPs from LRS for certified providers.
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:
Skilled Nursing

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Services listed in the approved POC that are medically necessary and may only be provided by a registered nurse, nurse practitioner, or a licensed practical nurse working under the supervision of a registered nurse. Since Skilled Nursing Services are an extended state plan service, participants must exhaust all available skilled nursing visits provided under Louisiana Medicaid State Plan Services prior to receiving this service through the waiver.

Skilled Nursing services must have a physician's order, a physician's letter of medical necessity, 90-L and Home Health plan of care (Form 485), an individual nursing service plan, a summary of medical history, and the skilled nursing checklist. Nurse submits updates every 60 days of any changes to participant's needs and/or Physician's orders. Nursing consultation services are available to participants that require short term nursing consults as part of their POC for family training, skills development, etc.

When there is more than one participant in the home receiving skilled nursing services, services may be shared and payment must be coordinated with the service authorization system and each participant's approved POC. Nursing consultations are offered on an individualized basis only.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
OCDD WSS Regional Staff can approve up to 12 hours per day of Skilled Nursing services. All requests for over 12 hours of skilled nursing per day must be reviewed and approved by the DHH Medical Director and Medical Evaluation Team.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Skilled Nursing

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify)*:
Must be licensed according to Louisiana Revised Statues 40:2116.31.
Certificate *(specify)*:
Other Standard *(specify)*:
Must be enrolled as a Medicaid Home Health Provider.
Verification of Provider Qualifications
Entity Responsible for Verification:
Louisiana Department of Health, Office of Management and Finance, Health Standards Section

For Home Health Agency employees: RN: Louisiana State Board of Nursing LPN: Louisiana State Board of Practical Nurse Examiners
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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Specialized medical equipment and supplies are specified devices, controls, or appliances, specified in the plan of care, which enable individuals 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 State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. 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.

Case managers shall pursue and document all alternate funding sources that are available to the participant, and alternate funding sources the participant may be eligible, before submitting a request for approval to purchase or lease Specialized Medical Equipment and Supplies.

To avoid delays in service provisions/implementation, the Support Coordinator 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 thos durable and non-durable items that are available under the Medicaid State Plan. Support coordinators 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:
A cap of $1,000 for a 3 year period for this service will be per individual. On a case by case basis, with supporting documentation and based on need, an individual may be able to exceed this cap with the approval of OCDD and with the limits beyond the capped prior authorized.

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	Assistive Devices

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

Certificate *(specify)*:

Other Standard *(specify)*:

Must meet all applicable vendor standards and/or requirements for manufacturing, design and installation of technological equipment and supplies.
Enrolled as a Medicaid provider.

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Fiscal Intermediary

Frequency of Verification:
Initially and Annually

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:
Adult Companion Care

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Adult Companion Care services are provided by a companion who is employed or contracted by a Medicaid enrolled provider agency. The companion lives as a roommate with the participant and must be at least eighteen years of age. The companion is available in accordance with a pre-arranged time schedule as outlined in the Plan of Care (POC). The companion is available to be contacted by telephone for crisis support on short notice as outlined in the POC. Adult Companion Care Services assist the waiver participant to achieve and/or maintain the outcomes of increased independence, productivity, inclusion in the community as outlined in the

participant's POC.

This services includes assistance with all Activities of Daily Living (ADLs). Community integration and coordination of transportation services are provided by the companion. The companion is responsible for participating in and abiding by the POC as well as maintaining records in accordance with State requirements.

The provider agency must follow the following provisions:
• arranging the delivery of services;
• providing emergency services as needed;
• completing an initial and periodic inspections;
• contacting the companion a minimum of once per week or as specified in the POC;
• providing 24 hour oversight, back-up, and supervision;
• providing relief staff for scheduled and unscheduled absences, available for up to 360 hours (15 days) per year as authorized by the POC (relief staff for scheduled and unscheduled absences are included in the provider's rate);
• facilitating the development of a written agreement which is a part of the participant's POC; and
• defining all shared responsibilities between the companion and the participant including but not limited to types of support provided by the companion, activities provided by the companion and a typical weekly schedule.

Revisions to this agreement must be facilitated by the participant's provider agency in agreement with the participant and in conjunction with the support coordinator and support team.

The companion is an employee of the provider agency and is paid a flat daily rate to provide Adult Companion Care Services as included in the approved POC. The companion is responsible for meeting all financial obligations as agreed upon in the agreement between the provider agency, the participant and the companion.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Payment will not be made for services provided by a relative who is:
•Legal guardian of an adult with developmental disabilities;
•Spouse

Adult Companion Care services cannot be provided or billed for at the same time as Respite Care Services.

Participants receiving Adult Companion Care Services are not eligible for receiving Supported Independent Living, Individual and Family Support, Substitute Family Care, and Skilled Nursing.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Care Attendant
Agency	Monitored In Home Caregiving

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Companion Care

Provider Category:
Agency
Provider Type:
Personal Care Attendant
Provider Qualifications
License *(specify):*
Home and Community Based Services Provider Licensing Standard LAC Title 48, Part I, Subpart 3, Chapter 50
Personal Care Attendant Module
Certificate *(specify):*
Other Standard *(specify):*
Verification of Provider Qualifications
Entity Responsible for Verification:
Louisiana Department of Health, Office of Management and Finance, Health Standards Section
Frequency of Verification:
Initially, annually, and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Companion Care

Provider Category:
Agency
Provider Type:
Monitored In Home Caregiving
Provider Qualifications
License *(specify):*
Home and Community Based Services Provider Licensing Standard LAC Title 48, Part I, Subpart 3, Chapter 51 Monitored In-Home Caregiving Module
Certificate *(specify):*
Other Standard *(specify):*
Verification of Provider Qualifications
Entity Responsible for Verification:
Louisiana Department of Health, Office of Management and Finance, Health Standards Section
Frequency of Verification:
Initially, annually, and as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Integration and Development

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Community Integration and Development is the development of opportunities to assist individuals in becoming involved in their community with the creation of natural supports. The purpose is to encourage and foster the development of meaningful relationships in the community, reflecting the person's choices and values. For example: doing preliminary work toward membership in civic, neighborhood, church, leisure, etc. groups. This service differs from day habilitation in that it is building community relationships and not focused on vocational based training.

• To utilize this service, the recipient may or may not be present
• It will be person-centered, plan-driven, with a cap of 60 hours per recipient per POC year, which includes the combination of shared and non-shared CID.
• CID services may be shared by staff for up to three waiver participants who have a common direct service provider agency.
• Transportation cost is included in the rate paid to the provider.

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

There will be a cap of 60 hours per individual in 12 consecutive months.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Care Attendant
Agency	Supervised Independent Living

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration and Development

Provider Category:
Agency
Provider Type:
Personal Care Attendant
Provider Qualifications
License *(specify):*
Home and Community Based Services Provider Licensing Standard LAC Title 48, Part I, Subpart 3, Chapter 50
Personal Care Attendant Module
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Louisiana Department of Health, Office of Management and Finance, Health Standards Section
Frequency of Verification:
Intially, annually, and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration and Development

Provider Category:
Agency
Provider Type:
Supervised Independent Living
Provider Qualifications
License *(specify):*
Home and Community Based Services Provider Licensing Standard LAC Title 48, Part I, Subpart 3, Chapter 50, Supervised Independent Living Module
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana Department of Health, Office of Management and Finance, 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:
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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Necessary physical adaptations to the home or vehicle, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. These services are provided in accordance with Medicaid regulations and the participant's approved POC.

Home modification funds are not intended to cover basic construction cost. Waiver funds can be used to cover

the difference between constructing a bathroom and building an accessible or modified bathroom, but in any situation must pay for a specific approved adaptation.
• Such adaptations may include the installation of ramps and 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 which are necessary for the welfare of the individual. Modifications may be applied to rental or leased property with the written approval of the landlord and approval of OCDD WSS.
• Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, exterior fencing, general home repair and maintenance etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

Vehicle modifications are designed to help the participant function with greater independence. Such adaptations to the vehicle may include a lift, or other adaptations to make the vehicle accessible to the participant, or for the participant to drive.
• Excluded are those adaptations, which are of general utility, or for maintenance of the vehicle, or all providers must meet any state or local requirements for licensure or certification, as well as the person performing the service (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.

Any services covered by Title XIX (Medicaid State Plan Services) are excluded and any services denied are not reimbursable.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A cap of $7,000 for a 3 year period for this service will be per participant. On a case by case basis, with supporting documentation based on need, a participant may be able to exceed this cap with the approval of OCDD State Office.

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	Environmental Assessiblity Adaptations

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:
Environmental Assessiblity Adaptations
Provider Qualifications
License *(specify)*:
Environmental Modification providers must meet all applicable state and local (City or Parish) requirements (i.e., building contractors, plumbers, electricians, or engineers).

Certificate *(specify):*

Other Standard *(specify):*
Must be enrolled as a Medicaid Environmental modification provider and on the Freedom of Choice list for providers.

Verification of Provider Qualifications

Entity Responsible for Verification:
LDH Bureau of Health Services Financing

Frequency of Verification:
Initially and Annually

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

○ **Service is included in approved waiver. There is no change in service specifications.**

○ **Service is included in approved waiver. The service specifications have been modified.**

◉ **Service is not included in the approved waiver.**

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:
One-Time Transitional

HCBS Taxonomy:

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
One Time Transitional Services are one-time, set-up expenses for individuals who make the transition from an ICF/DD to their own home or apartment in the community of their choice. Expenses can be utilized for security deposits that are required to obtain a lease on an apartment or home and set up fees or deposits for utilities (telephone, electricity, heating by gas) and essential furnishings to establish basic living arrangements which are bed, chair, a dining table and chairs, eating utensils, and food preparation items and a telephone. The expenses can also cover health and safety assurances, such as pest eradication, allergen control, or one-time cleaning prior to occupancy. Security deposits do not include rental payments.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• One time life time maximum service of $3,000 per individual. Service expenditures will be tracked by MMIS and OCDD data files and through prior and post authorization records.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transitional Support

Appendix C: Participant Services

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

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

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

Certificate *(specify):*

Other Standard *(specify):*
BHSF (Medicaid)provider enrollment agreement
Verification of Provider Qualifications

Entity Responsible for Verification:
DHH-Health Standards Section
Frequency of Verification:
Initally, 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:
Personal Emergency Response

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Personal Emergency Response System (PERS) is an electronic device which enables individuals to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals.

PERS services are available to individuals who have a demonstrated need for quick emergency back-up, are unable to use other communication systems as they are not adequate to summon emergency assistance, or do not have 24 hour direct supervision.

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

Coverage of the PERS is limited to the rental of the electronic device. PERS services shall include the cost of maintenance and training the recipient to use the equipment. Reimbursement will be made for an installation fee for the PERS unit. A monthly fee will be paid for the maintenance of the PERS.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Emergency Response System

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response

Provider Category:
Agency
Provider Type:
Personal Emergency Response System
Provider Qualifications

License *(specify):*
Not applicable
Certificate *(specify):*
Qualifications for those working in the response centers are certified "Emergency Medical Dispatcher". Job qualifications include: A certified Emergency Medical Dispatcher is a professional telecommunicator, tasked with the gathering of information related to medical emergencies, the provision of assistance and instructions by voice, prior to the arrival of Emergency Medical Services, and the dispatching and support of EMS resources responding to an emergency call. The term Emergency Medical Dispatcher is a certification level and a professional designation, certified through the National Academies of Emergency Dispatch. The Emergency Medical Dispatcher will fill a number of critical functions, including the identification of basic call information, including the location and telephone number of the caller, the location of the patient, the general nature of the problem, and any special circumstances. The EMD Dispatcher will then use an approved set of protocols to provide first aid and pre-arrival assistance to the subscriber and/or bystander.
Other Standard *(specify):*
Agency must be enrolled in Medicaid to provide personal emergency response system. The provider shall install and support PERS equipment in compliance with all applicable federal, state, county (parish) and local laws and regulations and meet manufacturer's specifications, response requirements, maintenance records, and enrollee education.

Verification of Provider Qualifications

Entity Responsible for Verification:
MOLINA for Medicaid Enrollment of providers
City or Parish issuing business license
Frequency of Verification:
Initially and annually
As required per the City and/or Parish

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Professional Services

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Professional Services are direct services to participants, based on need, and specified in an approved POC. Children who participate in the New Opportunities waiver will receive these services through EPSDT.

Professional services offered are: social work services, psychological (psychologist), and dietitian/nutritionist. Professionals providing these services must be contracted or employed by an enrolled Personal Care Attendant provider, Supported Living provider, or a Home Health agency and licensed in their area of expertise with one-year minimum of experience post licensure.

Professional services may be utilized to:

• Assist in increasing the individual's independence, participation and productivity in their home, work and community

• Provide training or therapy to an individual and/or their natural and formal supports, necessary to either develop critical skills that may be self-managed by the individual or maintained according to the individuals needs,

• Perform assessments and/or re-assessments and recommendations

• Intervene in and stabilize a crisis situation (behavioral or medical) that could result in the loss of home and community-based services.
• Provide consultative services and recommendations
• Provide necessary information to the individual, family, caregivers, and/or team to assist in planning and implementing plans per the approved plan of care.
Service intensity, frequency, and duration will be determined by individual need. The services may be short-term, intermittent, or long-term, depending on the need. Determinations for service utilization are made by the team developing the plan of support.

The participant may utilize one or more professional services in the same day but not at the same time.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
There is a $2,250 per individual, per plan of care year cap for professional services.
Additional services can be prior authorized if the individual reaches the cap before the expiration of the plan of care year and the individuals health and safety are at risk.

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	Social Worker
Individual	Dietician/Nutritionist
Agency	Home Health Agency
Agency	Supervised Independent Living
Individual	Psychologist
Agency	Personal Care Attendant

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Individual
Provider Type:
Social Worker
Provider Qualifications
License *(specify)*:
Social Worker: Louisiana Board of Certified Social Work Examiners: Louisisana Revised Statues 37:2701-2723
Certificate *(specify)*:
Not applicable
Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:

Louisiana State Board of Social Work Examiners
Frequency of Verification:
Initally, annually and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Individual
Provider Type:
Dietician/Nutritionist
Provider Qualifications
License *(specify):*
Dietician/Nutritionist: State Board of Examiners in Dietetics and Nutrition for State of Louisiana: Louisiana Revised Statues 37:3086
Certificate *(specify):*
Not applicable
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Louisiana Board of Examiners in Dietietics and Nutrition
Frequency of Verification:
Initially, annually and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Home Health Agency: Louisiana Revised Statutes 40.2116.31-2116.40
Certificate *(specify):*
Not applicable.
Other Standard *(specify):*
Must be enrolled as a Medicaid Home Health Provider
Verification of Provider Qualifications
Entity Responsible for Verification:
Louisiana Department of Health, Bureau of Health Services Financing, Health Standards Section

For Home Health Agency employees: RN: Louisiana State Board of Nursing LPN: Louisiana State Board of Practical Nurse Examiners
Frequency of Verification:
Initially, annually, and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Agency

Provider Type:
Supervised Independent Living

Provider Qualifications

License *(specify):*
Home and Community Based Services Provider Licensing Standard LAC Title 48, Part I, Subpart 3, Chapter 50, Supported Independent Living Module

Certificate *(specify):*
Not applicable.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana Department of Health, Bureau of Health Services Financing, Health Standards Section

Frequency of Verification:
Initially, annually, and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Individual

Provider Type:
Psychologist

Provider Qualifications

License *(specify):*
Psychologist: Louisiana State Board of Examiners of Psychologists: Louisiana Revised Statues 37:2356

Certificate *(specify):*
Not applicable.

Other Standard *(specify):*

Verification of Provider Qualifications

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

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Agency

Provider Type:
Personal Care Attendant

Provider Qualifications

License *(specify):*
Home and Community Based Services Provider Licensing Standard LAC Title 48, Part I, Subpart 3, Chapter 50
Personal Care Attendant Module

Certificate *(specify):*
Not applicable.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana Department of Health, Office of Management and Finance, 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:
Substitute Family Care (SFC)

HCBS Taxonomy:

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Substitute Family Care services is the Louisiana service title for the CMS core definition Adult Foster Care. Substitute Family Care services include personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) are provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Substitute Family Care in Louisiana is licensed as Substitute Family Care agencies.

Substitute Family Care is furnished to participants age 18 and older who receive these services in conjunction with residing in the home. The total number of individuals (including persons served in the waiver) living in the home, unrelated to the principal care provider, cannot exceed three.

Substitute Family Care participants may receive Individual and Family Supports services. Payments are not made for room and board, items of comfort or convenience, or the cost of facility maintenance, upkeep and improvement. Payment does not include payments made, directly or indirectly to members of the participant's immediate family.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Substitute Family Care services are limited to one service per day.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Substitute Family Care

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Substitute Family Care (SFC)

Provider Category:
Agency
Provider Type:
Substitute Family Care
Provider Qualifications
License *(specify):*
Home and Community Based Services Provider Licensing Standard LAC Title 48, Part I, Subpart 3, Chapter 50, Substitute Family Care Module

Certificate *(specify):*
Not applicable.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Louisiana Department of Health, Office of Management and Finance, Health Standards Section
Frequency of Verification:
Initally, annually, and as necessary

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:

Private case management agencies are licensed by LDH and enrolled as a Medicaid provider of case management services.

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 Standard LAC Title 48, Part I, Subpart 3, Chapter 92, Direct Service Worker Registry, criminal history/ background checks are conducted "on all new employees prior to allowing the employee to work directly with individuals receiving HCBS services." The scope of the history or background checks is not mandated but at a minimum the Louisiana State Police (LSP) or their designee conduct a statewide level check.

- The Louisiana State Police (LSP), or the LSP designee companies they recognize as competent, perform the

actual criminal history/background checks and security check on the individual.
• A sample of employee background checks/security checks are reviewed by Health Standards Section during licensing and monitoring reviews. Health Standards (HSS) is the regulatory agency for LDH. HSS licenses direct service providers (DSP) and ensures compliance with the applicable rules and regulations. Licensing standards require that DSPs conduct criminal history back ground checks and sex offender checks on all non-licensed personnel at the time an offer of employment is made. HSS surveyors will assess the provider's compliance with the requirement at the time surveys are conducted.

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:
• 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.

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 Direct Service Worker Registry is managed under contract by the Louisiana Board of Examiner for Nursing Facility Administrators. All direct service providers are required to check the registry prior to hiring a worker to assure that there have been no findings of abuse, neglect, misappropriation, exploitation or extortion placed against a worker. Compliance is verified by Health Standards at the time of on site surveys of provider agencies. Senate Bill 271 (Act 306) of the 2005 legislative session established the registry and directed LDH to publish rules and regulations. The DSW rule was published November 20, 2006.

Appendix C: Participant Services

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

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

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

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

Appendix C: Participant Services

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

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

services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

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

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

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

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

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

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

- ( ) **Other policy.**

Specify:

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

• Willing and qualified providers can access information on becoming an enrolled waiver service provider several ways:
• Via the Louisiana Medicaid website;

• Through state facilitated stakeholder meetings regarding waiver services; and
• Through state facilitated meetings with provider organizations such as ARC of Louisiana, 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:
• All willing and qualified providers have the opportunity to enroll as waiver service providers by first submitting a facility needs review packet to LDH, Office of Management and Finance, Health Standards Section. Upon approval of the facility needs review, a license is issued.
• After obtaining a license, the provider applicant must complete and sign a Louisiana Provider Enrollment form (PE-50) to participate in the Medicaid program;
•BHSF, or its designee, reviews all information, and makes a determination whether to enroll the provider in the Medicaid program;
• BHSF, or its designee assigns each new enrolled provider a unique Medicaid number and sends the OCDD this information;
• The Provider's name is then added to the Freedom of Choice list;
• BHSF trains all waiver providers in licensing and certification procedures and requirements;
• BHSF, OCDD, or its agent train waiver providers in the proper procedures to follow in submitting claims to the Medicaid program Fiscal Intermediary Provider relations handles all questions concerning the submission of claims;
• BHSF is responsible for insuring that waiver providers remain in compliance with all rules and regulations required for participation in the Medicaid program; and
•Fiscal Intermediary, 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 provider enrollment on-site visit. The provider is listed on the Provider Freedom of Choice form for the appropriate regions for which they have completed enrollment and licensure. (Health Standards Section) notifies the OCDD State Office when an enrolled provider is removed from the active Medicaid provider file and Freedom of Choice list. Notification will include the reason and the date of closure.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
C.a.i.a.1. Number and percentage of new HCBS provider applicants who meet HCBS licensing standards prior to furnishing waiver services. Percentage = Number of HCBS provider applicants who initially meet HCBS licensing standards prior to furnishing waiver services. / Total number of initial HCBS applicants

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
C.a.i.a.2. Number and percentage of HCBS providers that continually meet HCBS licensing standards. Percentage = Number of HCBS providers that continually meet HCBS licensing standards / Total number of licensed HCBS providers

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

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

Data Aggregation and Analysis:

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

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

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

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

	☐ Other Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

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

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

☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

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

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

employees who pass the initial background screening / Total number of newly hired self-direction employees reviewed in the sample.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: 10% random sampling review of all background check reports.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

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

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

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

	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

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

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

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 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 Agent	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

C.a.i.c.1: LDH is required to maintain a registry of individuals to include information concerning any documentation of any investigation for findings of abuse, neglect, extortion, exploitation and misappropriation of property, including a summary of findings after an action is final. Employers must use the registry to determine if a prospective hire is registered and if there is a finding of abuse, neglect or misappropriation. An individual may not be hired unless s/he is in good standing or s/he is a trainee enrolled in a training program of a provider or school with an approved training curriculum.

C.a.i.a.3: A provisional license may be issued to a provider that has deficiencies which are not a danger to

the health and welfare of clients. They are issued for a period up to six months. A license may not be renewed or may be revoked when applicable licensing standards are not met.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
For services provided in the NOW, the general remediation procedure the State utilizes if for the LGE staff to review data on corrective actions and identify which items are unclear or need revision. Staff work with the provider to ensure that the corrective action plan is clear, reasonable and has been implemented to address the concerns.

C.a.i.a.1 and C.a.i.a.2: For every deficiency cited, the provider must 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 deficienc(ies). The plan of correction will require the provider to give a completion date (no more than 60 days) for each deficiency as well as the staff person responsible for monitoring and assuring continued compliance. Failure to come into substantial compliance could result in non-renewal, license revocation with cancellation of the Medicaid provider agreement. Civil monetary penalties may be imposed for deficiencies resulting in abuse, neglect, actual harm or death to a client or when there are repeat deficiencies within 18 months. Failure to pay the fine results in withholding the money from vendor payment.

C.a.i.a.2: If a provisional license is issued, the provider will be reviewed at the end of the provisional license period to determine compliance. If the provider is still not in compliance, the license may not be renewed or license revocation may be initiated.

C.a.i.b.2: OCDD will monitor a random sample of 10% of newly hired staff for participant's who have chosen the self-direction option to ensure that background screenings have been done. If it is found that staff was allowed to work without a background screening, remediation will be required from the Fiscal Agent.

C.a.i.c.2: Self-Directed Employers/participants are required to ensure their staff have been trained according to the policies and procedures in place. If the Fiscal Agent reports that staff's credentials have lapsed, that staff person will not receive payment until credentials have been renewed/acquired.

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: Health Standards Section and Fiscal Agent	☑ **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.