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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

A. The **State** of **Louisiana** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Residential Options Waiver (ROW)

C. Waiver Number:LA.0472

D. Amendment Number:

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

10/01/23

Approved Effective Date of Waiver being Amended: 07/01/23

2. Purpose(s) of Amendment

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

Appendix C: Adding Financial Management as a service
Appendix H: Add language regarding composite sampling: Additionally, beginning in 2018 with the amendment of the Residential Options Waiver (LA.0472.R01.04), OCDD began utilizing composite sampling and consolidated evidence reporting across its four developmental disabilities waivers in accordance with CMS' quality memo "Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers" released in 2014. These changes served to streamline monitoring, remediation, and reporting for all four waivers and results in increased efficiency to discovery methods and implementing systemic improvements.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	

Component of the Approved Waiver	Subsection(s)
☐ Appendix A Waiver Administration and Operation	
☐ Appendix B Participant Access and Eligibility	
☒ Appendix C Participant Services	C1-C3
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☒ Appendix H	H-1
☐ Appendix I Financial Accountability	
☒ Appendix J Cost-Neutrality Demonstration	J2-d

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

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☒ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☐ **Other**

Specify:

1. Request Information (1 of 3)

A. The **State** of **Louisiana** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Residential Options Waiver (ROW)

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Draft ID: **LA.005.03.01**

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/23
Approved Effective Date of Waiver being Amended: 07/01/23

PRA Disclosure Statement

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

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

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

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

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

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

LA.0005 Dental Benefit Program (PAHPs)

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

☒ **§1915(b)(1) (mandated enrollment to managed care)**

☒ **§1915(b)(2) (central broker)**

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

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

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

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The purpose of the Residential Options Waiver, a 1915 C waiver, is to assist participants in leading healthy, independent and productive lives to the fullest extent possible and promote the full exercise of their rights as citizens of the state of Louisiana. Services are provided with the goal of promoting independence through strengthening the participant's capacity for self-care and self-sufficiency. The Residential Options Waiver is person-centered incorporating the participant's support needs and preferences with a goal of integrating the participant into their community. The Residential Options Waiver provides opportunities for eligible individuals with developmental disabilities to receive HCBS services that allow them to transition to and/or remain in the community.

The objectives of the Residential Options Waiver are to:

Promote independence for participants through the provision of services meeting the highest standards of quality and national best practices, while ensuring health and safety through a comprehensive system of participant safeguards;

Offer an alternative to institutionalization and costly comprehensive services through the provision of an array of services and supports that promote community inclusion and independence by enhancing and not replacing existing informal networks; and

Offer access to services which would protect the health and safety of the participant.

The Louisiana Department of Health (LDH) Bureau of Health Services Financing (BHSF) is the Single State agency which maintains administrative and supervisory oversight of the ROW. The department within BHSF which has oversight authority of the Residential Options Waiver is the Medicaid Program Support and Waivers (MPSW) section. BHSF MPSW designates the authority for implementing the program(s) and for programmatic oversight of the waiver to the responsible entity, Office for Citizen's with Developmental Disabilities (OCDD) with responsibility for day to day operations delegated to Human Services Authorities or Districts. This authority has been made through a Memorandum of Understanding between LDH BHSF Medicaid Program Support and Waivers and OCDD. A separate Memorandum of Understanding has also been established between BHSF Medicaid Program Support and Waivers and the Human Services Districts or Authorities.

Legislation passed in 2008, 2012, and 2013 created Human Services Districts or Authorities referred to as Local Governing Entities (LGE). The LGEs are the regional arm of OCDD to direct the operation and management of services for developmental disabilities. There are ten LGEs' offices within the state of Louisiana who manage the day to day operations of the ROW for citizens within their geographic location.

Services are accessed through a single point of entry in the LGE. When criteria are met, individual's names are placed on the registry. All waiver participants choose their Support Coordination and Direct Service Provider Agencies through the Freedom of Choice process. As part of OCDD's Tiered Waiver approach, all children under age 22 enter the waiver system into the Children's Choice Waiver and all adults enter into the Supports Waiver. A person-centered planning process, which includes completion of a needs-based assessment, is utilized during the initial phase to develop the individual's life vision/goals and develop support strategies and identify services/supports needed. If an individual's needs cannot be met with the initial waiver they may request moving up to the next waiver in the Tiers- the Residential Options Waiver. The ROW is the second tier within the OCDD Tiered Waiver process. The initial plan of care (POC) is developed during this person-centered planning process and approved by the LGE. Case Management Agencies are designated as Support Coordination agencies throughout this application. All services must be prior authorized and delivered in accordance with the approved plan of care. Prior authorization is completed by a contracted data source with LDH. The average participant's expenditures for all waiver services shall not exceed the average Medicaid expenditures for ICF/IID services.

3. Components of the Waiver Request

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

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- (●) **No**
- ( ) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

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

5. Assurances

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

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the

waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of

care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

The Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF) and the Office for Citizens with Developmental Disabilities (OCDD) currently provides home and community-based services through the Residential Options Waiver (ROW) to eligible Medicaid recipients.

LDH hereby gives public notice of its intent to seek approval from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) for an amendment of its application for the Residential Options Waiver program.

In compliance with CMS requirements, OCDD is posting the Residential Options Waiver amendment application for public comment from March 31, 2023 through April 30, 2023. CMS regulations require the Louisiana Department of Health to actively engage the public and give program participants, advocates, providers and other community stakeholders the chance to provide input regarding changes made to current waiver applications prior to submission of final versions to CMS.

The Residential Options Waiver amendment application (LA.005.03.01) is posted to the OCDD website and may be accessed at the following address: (https://ldh.la.gov/page/2526). A hard copy of the application is available for viewing at the Human Services District/Authority (HSD/A) in your region. The HSD/A in your region can be found at: https://ldh.la.gov/page/134, or by calling 866-783-5553. Implementation of the provisions of this waiver amendment is contingent upon CMS approval.

Interested persons may submit written comments to the Office for Citizens with Developmental Disabilities, P.O. Box 3117 (Bin #21), Baton Rouge, LA 70821-3117 or by email to ocdd-hcbs@la.gov. The deadline for receipt of all written comments is April 30, 2023 by 4:30 p.m.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Bennett

First Name: Brian

Title: Section Chief

Agency: Bureau of Health Services Financing

Address: 628 N. 4th Street

Address 2: P.O. Box 91030

City: Baton Rouge

State: **Louisiana**

Zip: 70821

Phone: (225) 342-9846 **Ext:** ☐ **TTY**

Fax: (225) 342-9168

E-mail: brian.bennett@la.gov

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

Last Name: Hagan

First Name: Julie

Title: Assistant Secretary

Agency: Office for Citizens with Developmental Disabilities

Address: 628 N. 4th Street

Address 2:

City: Baton Rouge

State: **Louisiana**

Zip: 70821

Phone: (225) 342-0095 **Ext:** ☐ **TTY**

Fax: (225) 342-8823

E-mail: Julie.Hagan@LA.GOV

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Bennett

First Name: Brian

Title: Section Chief

Agency: Bureau of Health Services Financing

Address: 628 N.4th St

Address 2:

City: Baton Rouge

State: **Louisiana**

Zip: 70802

Phone: (225) 342-9846 **Ext:** ☐ **TTY**

Fax: (225) 342-9168

E-mail: Brian.Bennett@la.gov

Attachments

Attachment #1: Transition Plan

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

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

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

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

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

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

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

"The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan."

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix I-2A continued:
Please refer to LA.0005, Section D and accompanying Cost Effectiveness workbook for rate determination methods. Dental services are capitated and rates are submitted to CMS for approval as part of the Dental Benefit Plan Manger (PAHP) rate certification and contract amendment process.The State's implementation of Electronic Visit Verification (EVV) has not impacted rates for services subject to EVV. Fiscal Management Services: The Medicaid agency determines the rate for Fiscal Management Services. The state uses the Fee Schedule model of rate setting for this service. The initial rate was determined in November 2022 using rates included in contracts executed as a result of the state's last Request for Proposal process in 2019. Rates for the two contractors were averaged to calculate the base rate for this service. An add-on to this rate was calculated to cover the cost of criminal background checks using six months of historical costs for background checks invoiced by the contractors. Each provider will submit its cost data at least every five years to determine if a change in the base rate is warranted. The add-on component for criminal background checks will be re-calculated using actual cost data from providers at least every five years. The ability to adjust rates is contingent on the availability of appropriated funding in the state budget.

Appendix I-1 continued:Post payment reviews are conducted throughout the year. Cases are open based on various sources. SURS operates a hotline where complaint calls are received that pertain to fraud, waste and abuse. Additionally, SURS receives complaints via the Louisiana Department of Health website, mail and fax. Complaint cases are triaged and then opened each month. Another source of cases openings is Recipient Explanation of Benefits (REOMBs). Each month, REOMBs are sent to a random sample of recipients, and based on the recipients' responses, cases are opened. Cases are also opened as a result of data mining. Data mining runs are done throughout the year. Some runs like the Surge Run and the HCPCS Outlier run are done annually, and cases are opened based on the results, and other runs like Home and Community Based Services (HCBS) and Inpatient Stay overlaps are done periodically.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

○ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

◉ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

The Office for Citizens with Developmental Disabilities

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The State Medicaid Agency, BHSF, and the operating agency OCDD, have an Interagency Agreement (IA) defining the responsibilities of each. The IA is to be reviewed yearly and updated as necessary. Among other activities, this interagency agreement requires BHSF and OCDD to meet quarterly to evaluate the waiver program and initiate necessary changes to policy and/or reimbursement rates and to meet quarterly with the Division of Health Economics to review the financial accountability reports for the waiver program.
There are ten Local Governing Entities (LGE) offices within the state of Louisiana which contract with BHSF to perform regional waiver operation functions for the OCDD waivers as delegated and described in the CMS approved waiver document. The LGE offices perform under the guidance and supervision of OCDD, the state waiver operating agency. The LGE must comply with all regional Quality Improvement Strategy activities as described in the approved waiver document. Both the state operating agency (OCDD) and each of the LGE share responsibility to meet the federally mandated assurances and sub-assurances for: Level of Care; Service Plan; and Health and Welfare. The contract agreements with the LGE are to be reviewed yearly and updated as necessary.
To ensure compliance with federal regulations governing waivers, BHSF created the Medicaid Program Support and Waivers Section (MPSW) which oversees the administration of the Medicaid Home and Community Based Services (HCBS) programs operated by OCDD and the Office of Aging and Adult Services (OAAS). Oversight is completed under the direction of the Medicaid Program Support and Waivers Section Chief.
Medicaid oversight of operating agency performance is facilitated through the following committees:

LDH Variance Committee – meets at least quarterly to review financial utilization and expenditure performance of all OCDD waivers. Members are composed of representatives from OCDD, Division of Health Economics, and MPSW.

Medicaid HCBS Oversight Committee - meets at least quarterly with the specific purpose to ensure proper oversight of the OAAS and OCDD operated HCBS Medicaid programs. Goals are to review current performance reports, determine need for new activities concerning quality and oversight in waiver programs and ensure adequate remediation enforcement. Quality recommendations or issues which cannot be resolved at this level are placed on the agenda of the Medicaid/Program Offices Quarterly Meeting. Members include HCBS quality management staff from MPSW and OCDD and it is chaired by the MPSW Section Chief or designee. The committee meets at least quarterly with the following standing agenda items:
--OCDD operating agency staff present their analysis of all performance measure findings, remediation activities and systemic improvements to MPSW as defined in the 1915(c) waiver quality strategy;
--MPSW Section Chief or designee indicates approval or disapproval of quarterly/annual data and activities;
--Based on evidence presented, MPSW staff provides technical assistance, guidance and support to the operating agency staff;
--MPSW performs administrative oversight functions for OCDD HCBS programs.

Medicaid/Program Offices Quarterly Meeting – Convenes at least quarterly to perform executive level oversight of the performance of HCBS waivers, assure their effectiveness and efficiency, and discuss any other programmatic issues common to the program offices and Medicaid. Goals are to act upon issues and recommendations received from the Medicaid HCBS Oversight Committee and other HCBS workgroups. This meeting is a forum for executive level problem resolution, planning, and development of quality redesign strategies. Members include representatives from MPSW, the Medicaid Director or Deputy Director, the OCDD Assistant Secretary, and other designated staff.
MPSW/OCDD/HCBS Data Contactor Meetings– MPSW facilitates monthly meetings with OCDD and the Medicaid data contractor to discuss waiver issues, problems, and situations which have arisen and do not comport with program policy. At these meetings solutions are formulated, corrective actions are agreed upon, follow-up implemented by OCDD as necessary in the form of internal policy or provider policy.

Ad Hoc Cross-Population HCBS Oversight Meetings - Additional meetings will be held jointly between MPSW, OCDD and the Office of Aging and Adult Services on an as needed basis for the following purposes:
--Collaborate on design and implementation of a robust system of cross- population continuous quality improvement;
--Present Quality Improvement Projects (QIP);
--Share ongoing communication of what works, doesn’t work, and best practices.

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

1. Participant waiver enrollment – BHSF maintains supervision by approving the process for entry of individuals into the waiver. Supervision of compliant entry processes occurs during the monthly MPSW/OCDD/HCBS Data Contractor Meetings.
2. Waiver enrollment managed against approved limits –The variance committee meets quarterly to manage waiver enrollment against approved limits. This committee is composed of representatives from OCDD, LDH's Division of Health Economics, and MPSW. This function is accomplished through the review of ongoing data reports received through the Medicaid data contractor and Medicaid Management Information Systems (MMIS). These data reports include the number of participants receiving services, exiting the waiver, offered a waiver opportunity, waiver closure summary, admissions summary, level of care intake, acute care utilization, and waiver expenditures.

3. Waiver expenditures managed against approved levels– MPSW is responsible for completing the annual CMS-372 report utilizing data, submitting it to OCDD for review, and submitting to the Medicaid Director for final approval prior to submission. The variance committee meets quarterly to manage waiver expenditures against approved limits. This committee is composed of representatives from OCDD, LDH's Division of Health Economics, and MPSW. This function is accomplished through the review of ongoing data reports received through the Medicaid data contractor and MMIS. These data reports include the number of participants receiving services, exiting the waiver, offered a waiver opportunity, waiver closure summary, admissions summary, level of care intake, acute care utilization, and waiver expenditures. The variance committee discusses waiver administration and reviews financial participation and budget forecasts in order to determine if any adjustments are needed.

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

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

6. Prior authorization of waiver services - To ensure that payments are accurate for the services rendered OCDD monitors and oversees the requirements of the provider through the prior authorization process and the approved plan of care (POC). BHSF oversees OCDD's exercise of prior authorization activities through reports issued by the Medicaid data contractor and through monthly MPSW/OCDD/HCBS Data Contractor Meetings. System changes related to claims processing and prior authorization can only be facilitated by BHSF. OCDD formally presents service plan performance measure findings/remediation actions to MPSW quarterly via the Medicaid HCBS Oversight Committee as described in Appendix D: QIS sub-assurance c.
7. Utilization management – Reports are generated quarterly from the Medicaid data contractor which include: number of participants who received all types of services specified in their service plan and number of participants who received services in the amount, frequency, and duration specified in the service plan. OCDD reviews these reports for trends and patterns of under-utilization of services. OCDD formally presents service plan performance measure findings/remediation actions to MPSW quarterly via the Medicaid HCBS Oversight Committee as described in Appendix D: QIS sub-assurance d.
8. Establishment of a statewide rate methodology - BHSF determines all waiver payment amounts/rates in collaboration with OCDD, Division of Health Economics, and as necessary the Rate & Audit section. MPSW monitors adherence to the rate methodology as described in Appendix I QIS.

9. Rules, policies, procedures, and information development governing the waiver program – OCDD develops and implements written policies and procedures to operate the waiver and must obtain BHSF approval prior to release of any rulemaking, provider notices, waiver amendments/requests or policy changes. BHSF develops and distributes brochures, flyers, and other informational material regarding available programs to Louisiana citizens. BHSF oversees the website information, as well as communication distribution via Help Lines regarding waiver eligibility and policy administration.
10. Quality assurance and quality improvement activities - To ensure compliance with federal regulations governing waivers, BHSF created the Medicaid Program Support and Waivers (MPSW) Section to oversee the

administration of all Louisiana Medicaid waiver programs. Monitoring is completed under the direction of the MPSW Section Chief. The MPSW Section, through performance measures listed in the Quality Improvement Strategy (QIS) and systems described in Appendix H, ensures that OCDD performs its assigned waiver operational functions including participant health and welfare assurances in accordance with this document. OCDD formally presents performance measures findings/remediation actions to MPSW quarterly via the Medicaid HCBS Oversight Committee.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

Medicaid Data/Prior Authorization Contractor - The Medicaid data contractor compiles and aggregates data on plans of care, such as date the initial plan is submitted and approved, date the annual POC is approved, and date the POC is received by the regional office. The Medicaid data contractor also compiles and aggregates data on support coordination, provider services, waiver slots (both occupied and vacant); compiles and aggregates information on time lines, offerings of waiver slots and linkages to support coordination agencies; compiles and aggregates data on the Waiver certification process; provides prior authorization functions; maintains the Request for Services Registry(RFSR); issues freedom of choice forms to the participant/family members to allow selection of a Support Coordination Agency; collects data from providers and provides various notifications to providers upon direction of OCDD or BHSF.

Fiscal/Employer Agent - The fiscal agent ensures participants' prior authorized service limits for self-directed services are not exceeded and processes employer-related payroll and necessary federal and state taxes on behalf of Self-Direction participants.

Support Coordination Agencies - Support coordination agencies enrolled in Medicaid to serve participants in the ROW perform delegated operational functions for level of care re-evaluation as described in B-6.f. and for review of participant service plans as described in D-1.d.

Provider Enrollment Contractor – The Provider Enrollment unit of the Fiscal Intermediary Contractor performs fee –for-service provider enrollment and execution of Medicaid provider agreements on behalf of Medicaid.

Dental Benefit Plan Manager will manage the dental benefit for the dental services. In accordance with contracts with the State, each dental plan will prior authorize services and contract with providers.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

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

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

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

The State Medicaid agency is responsible for the assessment of performance of contracted dental plans. (PAHPs)

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

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

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

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

Medicaid Program Support and Waivers staff meet bi-weekly to review contract work, issues, problems and deliverables.

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

BHSF requires the fiscal/employer agent to submit an annual independent audit by a Certified Public Accountant (CPA) to verify that expenditures are accounted for and disbursed according to generally accepted accounting principles. In addition, BHSF and OCDD utilize participant-satisfaction survey data gathered by the FMS and complaint data to assess the fiscal/employer agents performance. If any problems are identified, BHSF and OCDD will require a corrective action plan from the fiscal/employer agent and will monitor implementation.

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

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

Please reference La.0005 section b: monitoring plan

Appendix A: Waiver Administration and Operation

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

one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

A.a.i.6. Number and percentage of changes in waiver policies that were approved by BHSF and presented for public notice prior to implementation by the operating agency.Percentage = Number of changes in waiver policies that were approved by BHSF and presented for public notice prior to implementation by the operating agency / Total number of changes in waiver policies.

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

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

Data Aggregation and Analysis:

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

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

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

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
A.a.i.8. Number and percentage of waiver offers that were appropriately made across all geographical areas to applicants on the Request for Services Registry (RFSR), according to policy and criteria set forth by the State. Percentage = Number of appropriately made offers to applicants on the RFSR / Total number of waiver offers made

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
A.a.i.7. Number and percent of unduplicated participants who were certified in a waiver slot where the number of certified slots are less than or equal to those available.
Numerator=Number of unduplicated participants who were certified in a waiver slot.
Denominator=Total of available slots.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
A.a.i.3. Number and percentage of Quality Improvement Projects (QIPs) initiated and submitted to the MPSW Section within three months of findings below the 86% threshold. Percentage = Number of Quality Improvement Projects (QIPs) initiated and submitted to the MPSW Section within three months of findings below the 86% threshold / Total number of QIPs initiated and submitted to MPSW

Data Source (Select one):
Other
If 'Other' is selected, specify:
MPSW tracking system

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

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

Data Aggregation and Analysis:

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

Performance Measure:
A.a.i.4. Number and percentage of implemented QIPs that were effective as evidenced by meeting the 86% threshold upon the subsequent monitoring cycle. Percentage = Number of

implemented QIPs that were effective as evidenced by meeting the 86% threshold upon the subsequent monitoring cycle / Total number of implemented QIPs.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
A.a.i.5. Number and percentage of setting assessments completed where the provider was either compliant or progressing toward a plan for compliance with the HCBS Settings Rule. Percentage = Number of setting assessments completed where the provider was either compliant or progressing toward a plan for compliance with the HCBS Settings Rule / Total number of setting assessments

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
A.a.i.2. Number and percentage of performance measures which met the 86% threshold. Percentage = Number of performance measures which met the 86% threshold / Total number of performance measures due.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

		Review
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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.

The SMA retains administrative authority and responsibility of the waiver through its review of proposed changes to the waiver submitted by the operating agency that involve any of the delegated functions listed in Appendix A.7. Prior to posting for public/tribal notice, the SMA (Medicaid Program Support and Waivers section staff) reviews any changes proposed in the waiver amendment/renewal to ensure that the requested change aligns with Medicaid policy. This performance measure reflects the SMA's oversight of changes to waiver policy for all delegated functions not performed by the SMA.

b. Methods for Remediation/Fixing Individual Problems

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

A.a.i.1 – A.a.i.6
Aggregated data collected for Performance Measures A.a.i.1 – A.a.i.6 are reviewed and analyzed quarterly by via the Medicaid HCBS Oversight Committee. When remediation is indicated, the Committee discusses appropriate remediation activities to resolve identified compliance issues and address systemic improvements. To achieve this end, MPSW provides technical assistance, guidance, and support to the operating agency staff. Committee minutes document remediation actions and results of these actions are presented at subsequent meetings to verify effectiveness.
The Medicaid HCBS Oversight Committee meets at least quarterly with the specific purpose to ensure proper oversight of the OAAS and OCDD operated HCBS Medicaid programs. Goals are to review current performance reports, determine need for new activities concerning quality and oversight in waiver programs and ensure adequate remediation enforcement. Quality recommendations or issues which cannot be resolved at this level are placed on the agenda of the BHSF/Program Offices HCBS Executive Committee. Members of the Medicaid HCBS Oversight Committee include HCBS quality management staff from MPSW and OCDD and it is chaired by the MPSW Section Chief or designee.

A.a.i.7
MPSW and OCDD meet monthly with the Medicaid data contractor to discuss problems/issues identified and how to remediate. At these meetings, the members review the Daily Count of Offers, Linkages and Certifications report generated by the data contractor which includes: waiver slots available; pre-linkage, linkages to support coordinator; offers accepted; offers too recent for a response; vacancies to be offered; offers accepted and linked; recipients linked and certified; recipients linked and not certified. This report is reviewed and analyzed to determine whether the yearly maximum number of unduplicated participants offered a waiver opportunity is nearing the limit. If the yearly maximum number of unduplicated participants offered a waiver opportunity is approaching the limit, the state will submit a waiver amendment to CMS to modify the number of participants.
Remediation of specific problems/issues/discrepancies identified are addressed in the monthly meetings and documented in the Medicaid data contractor meeting minutes (which are shared with OCDD) and the MPSW Tracking System.

A.a.i.8
MPSW and OCDD meet monthly with the Medicaid data contractor to discuss problems/issues identified and how to remediate. At these meetings, the members review the Count of Slot Types report generated by the data contractor which includes: initial allocated slots; reallocated slots due to closures; current number of allocated slots; current number of slots linked; number of remaining slots open. This report is reviewed and analyzed to identify the number of slots available for offers. OCDD and MPSW supervise whether offers are made appropriately according to established policy and criteria. If there are instances identified where offers were made inappropriately, MPSW meets with the data contractor and OCDD to address the situation and develop a plan for corrective action for resolution.
Remediation of specific problems/issues/discrepancies identified are addressed in the monthly meetings and documented in the Medicaid data contractor meeting minutes (which are shared with OCDD) and the MPSW Tracking System.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☒ Intellectual Disability or Developmental Disability, or Both					
	☒	Autism	0		☒
	☒	Developmental Disability	0		☒
	☒	Intellectual Disability	0		☒
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

The State further specifies its target group(s) as follows:

OCDD waiver opportunities shall be offered based on the following groups:

1. Individuals living at publicly operated ICF-IIDs or who lived at a publicly operated ICF-IID when it was transitioned to a private ICF-DD through a cooperative endeavor agreement (CEA facility), or their alternates. Alternates are defined as individuals living in a private ICF-IID who will give up the private ICF-IID bed to an individual living at a publicly operated ICD-IID or to an individual who was living in a publicly operated ICF-IID when it was transitioned to a private ICF-IID through a cooperative endeavor agreement (CEA facility).

Individuals requesting to transition from a publicly operated ICF-IID are awarded a slot when one is requested, and their health and safety can be assured in an OCDD waiver. This also applies to individuals who were residing in a publicly operated facility at the time the facility was privatized and became a Cooperative Endeavor Agreement (CEA) facility.

2.Individuals on the registry who have a current unmet need as defined by a SUN score of urgent [3] or emergent [4] and the earliest registry date shall be notified in writing when a funded OCDD waiver opportunity is available and a waiver offer is available.
3.Individuals Transitioning from ICF/IID facilities utilizing ROW Conversion
4.Transition of eligible Individuals with Intellectual and Developmental Disability services in either OAAS Community Choices Wavier (CCW)or OAAS Adult Day Health Care Waiver(ADHC) to the ROW.

As enacted through R.S. 28:827 Act No. 286 of the 2010 Regular Legislative Session, any active duty member of the armed forces who has been temporarily assigned to work outside of Louisiana and any member of his/her immediate family who was qualified for and was receiving Louisiana Medicaid Waiver services for individuals with developmental disabilities at the time they were placed on active duty will be eligible to receive the next available waiver opportunity upon the individual's resumed residence in Louisiana.

Medicaid’s data contractor has responsibility for maintenance of the IDD Request for Services Registry (the registry). Slot offers are made for persons on the registry by the Medicaid data contractor based upon the above stated policies and procedures and as written in B-3-f. Also, BHSF/MPSW has oversight of the data contractor’s role in maintaining the registry according to policy. In addition, monthly meetings are held between the Medicaid data contractor, OCDD, and BHSF/MPSW to review and to assure adherence to these regulations along with fairness in slot allocations and distributions.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to

individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

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

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ( ) **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

  The limit specified by the state is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage: [ ]

  - ( ) **Other**

    Specify:

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- (●) **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

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

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

The cost limit specified by the state is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

◉ **Other:**

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

o The LGE or the Support Coordination Supervisor is responsible for approving each participant's Plan of Care relative to his/her health and safety needs being assured within the array of services selected and each provider's ability to deliver those services. This is done prior to service delivery and through communication with the support coordinator so that rejected Plans of Care may be revised with technical assistance from the LGE or Support Coordinator Supervisor.

o Each residential and vocational provider must document completion of their own service plans which mirror the Plan of Care. The support coordinator is responsible for reviewing and assuring that these plans correctly implement the objectives within the approved Plan of Care. The Support coordination Supervisor can approve annual plans of care based on OCDD policy.

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

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

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

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

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

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

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

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

In accordance with 42CFR 431.206, 210 and 211, participants receiving waiver services, and their legal representatives are sent a certified letter with return receipt to ensure the participant receives it by the appropriate LGE providing ten days advance and adequate notification of any proposed denial, reduction, or termination of waiver services. Included in the letter are instructions for requesting a fair hearing, and notification that an oral or written request must be made within ten days of receipt of a proposed adverse action by the LGE in order for current waiver services to remain in place during the appeal process. If the appeal request is not made within ten days, but is made within thirty days, all Medicaid waiver services are discontinued on the eleventh day; services that are continued until the final decision is rendered are not billable under the Medicaid waiver. If the final decision of the Administrative Law Judge is favorable to the appellant, services are re-implemented from the date of the final decision. An appeal hearing is not granted if the appeal request is made later than thirty days following receipt of a proposed adverse action sent by the LGE. Once a request for an appeal is received, the LGE must submit the request to the Division of Administrative Law - Office of the Secretary no later than seven calendar days after receipt. A copy of the letter and the response/request is kept in the participant's record at the appropriate LGE.

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

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

Anyone requesting an appeal has the right to withdraw the appeal request at any time prior to the hearing. The appellant may contact the Division of Administrative Law -Office of the Secretary directly, or may request withdrawal through the LGE. Requests for withdrawal are kept in the participant's record at the appropriate LGE.

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

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

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

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

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

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

☒ **Other safeguard(s)**

Specify:

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

ROW acuity/budget cap level(s) are based upon each participant's Inventory for Agency and Client Planning (ICAP) assessment tool results and may change as the participant's needs change. A reassessment of the participant's ICAP level will be conducted to determine the most appropriate support level. Participants may exceed assigned ROW acuity/budget cap level(s) to access defined additional support needs to prevent institutionalization on a case by case basis according to policy and as approved by the OCDD Assistant Secretary or his/her designee. If it is determined that the ROW can no longer meet the participant's health and safety and/or support the participant, the case management agency will conduct person centered discovery activities.

All Medicaid services options will be explored, including ICF/IID placement, based upon the assessed need.

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	2000
Year 2	2200
Year 3	2400
Year 4	2600
Year 5	2800

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

◉ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

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

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ◉ **Not applicable. The state does not reserve capacity.**
- ○ **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

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

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- ◉ **The waiver is not subject to a phase-in or a phase-out schedule.**
- ○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Entrance to the Residential Options Waiver
Allocation of Waiver Opportunities

OCDD maintains the intellectual/developmental disabilities request for services registry, hereafter referred to as "the registry," which identifies persons with intellectual and/or developmental disabilities who are found eligible for developmental disabilities services using standardized tools, and who request waiver services.
1. Services are accessed through a single point of entry in the LGE. When criteria are met, individual's names are placed on the registry and a screening of urgency of need (SUN) is completed.
2. Individuals determined to have current unmet needs as defined as a SUN score of urgent [3] or emergent [4] are offered a waiver opportunity.
3. As part of OCDD's Tiered Waiver approach, all children under age 22 enter the waiver system into the Children's Choice Waiver and all adults enter with current unmet needs into the Supports Waiver. A person-centered planning process, which includes completion of a needs-based assessment, is utilized during the initial phase to develop the individual's life vision/goals and develop support strategies and identify services/supports needed. If an individual's needs cannot be met with the initial waiver they may request moving up to the next waiver in the Tiers. The ROW is the second Tier within the OCDD Tiered Waiver process.
4. The request for services registry (RFSR) is arranged by the urgency of need and date of application for developmentally disabled (DD) waiver services.

OCDD waiver opportunities shall be offered based on the following priority groups:
a. Individuals living at publicly operated ICF-IIDs or who lived at a publicly operated ICF-IID when it was transitioned to a private ICF-IID through a cooperative endeavor agreement (CEA facility), or their alternates. Alternates are defined as individuals living in a private ICF-IID who will give up the private ICF-IID bed to an individual living at a publicly operated ICD-IID or to an individual who was living in a publicly operated ICF-IID when it was transitioned to a private ICF-IID through a cooperative endeavor agreement (CEA facility). Individuals requesting to transition from a publicly operated ICF-IID are awarded a slot when one is requested, and their health and safety can be assured in an OCDD waiver. This also applies to individuals who were residing in a publicly operated facility at the time the facility was privatized and became a Cooperative Endeavor Agreement (CEA) facility.

b. Individuals on the registry who have a current unmet need as defined by a SUN score of urgent [3] or emergent [4] and the earliest registry date shall be notified in writing when a funded OCDD waiver opportunity is available and a waiver offer is available.

c. Individuals Transitioning from ICF/IID facilities utilizing ROW Conversion.

d. Transition of eligible individuals with intellectual and Developmental Disability services in either OAAS Community Choices Wavier (CCW)or OAAS Adult Day Health Care Waiver(ADHC) to the ROW.

ROW Needs Based Assessment
Inventory for Client and Agency Planning (ICAP) is a standardized assessment instrument that is designed to assess the status, adaptive functioning, and service needs of an individual. The ICAP is applicable to participants of all ages (infant to adult). Information is obtained from the participant's family, advocate, and/or direct care staff. The ROW level of care and budget level is determined by the ICAP assessment. The ICAP results indicate which ROW level of care and budget level the participant meets. There are four level of care and budget levels within the ROW. There are four levels, level 1 is least needs to level 4 which is highest needs. A comprehensive plan of care is developed utilizing the information obtained from the discovery process and the ICAP assessment. Reassessments are conducted with significant life changes and at least annually. The assessment process should be ongoing and reflect changes in the participant's life, needs, personal outcomes and preferences.

All waiver participants choose their Support Coordination and Direct Service Provider Agencies through the Freedom of Choice process. The initial plan of care (POC) is developed during this person-centered planning process and approved by the LGE. Case Management Agencies are designated as Support Coordination agencies throughout this application. All services must be prior authorized and delivered in accordance with the approved plan of care. Prior authorization is completed by a contracted data source with LDH. The average participant's expenditures for all waiver services shall not exceed the average Medicaid expenditures for ICF/IID services.

As enacted through R.S. 28:827 Act No. 286 of the 2010 Regular Legislative Session, any active duty member of the

armed forces who has been temporarily assigned to work outside of Louisiana and any member of his/her immediate family who was qualified for and was receiving Louisiana Medicaid Waiver services for individuals with developmental disabilities at the time they were placed on active duty will be eligible to receive the next available waiver opportunity upon the individual's resumed residence in Louisiana.

Medicaid's data contractor has responsibility for maintenance of the IDD Request for Services Registry (the registry). Slot offers are made for persons on the registry by the Medicaid data contractor based upon the above stated policies and procedures. Also, BHSF/MPSW has oversight of the data contractor's role in maintaining the registry according to policy. In addition, monthly meetings are held between the Medicaid data contractor, OCDD, and BHSF/MPSW to review and to assure adherence to these regulations along with fairness in slot allocations and distributions.

BHSF/MPSW and OCDD have the responsibility to monitor the utilization of the ROW opportunities. At the discretion of BHSF and OCDD, specifically allocated waiver opportunities may be reallocated to better meet the needs of citizens with developmental disabilities in the State of Louisiana.

The State Medicaid Agency retains ultimate administrative authority and oversight for all Medicaid waiver programs. OCDD is required to provide State Medicaid Agency with all rulemaking, policy, proposed changes and waiver amendments prior to implementation.

Appendix B: Participant Access and Eligibility

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

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

- (●) **No**
- ( ) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional state supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ( ) **100% of the Federal poverty level (FPL)**
- ( ) **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Medically needy with spend down to or below the medically needy income standard using the state average monthly Medicaid rate for residents of Intermediate Care Facilities/Developmental Disability and other incurred expenses to reduce an individual's income.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- (●) **The following standard included under the state plan**

  Select one:

  - ( ) **SSI standard**
  - ( ) **Optional state supplement standard**
  - ( ) **Medically needy income standard**
  - (●) **The special income level for institutionalized persons**

    (*select one*):

    - (●) **300% of the SSI Federal Benefit Rate (FBR)**
    - ( ) **A percentage of the FBR, which is less than 300%**

      Specify the percentage: [ ]
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount: [ ]
  - ( ) **A percentage of the Federal poverty level**

    Specify percentage: [ ]
  - ( ) **Other standard included under the state Plan**

    Specify:

    [ ]

- ( ) **The following dollar amount**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.

- ( ) **The following formula is used to determine the needs allowance:**

  Specify:

  [ ]

- ( ) **Other**

  Specify:

  [ ]

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

- (●) **Not Applicable**
- ( ) **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

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

- ( ) **SSI standard**
- ( ) **Optional state supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

- ( ) **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

- ( ) **Not Applicable (see instructions)**
- ( ) **AFDC need standard**
- (●) **Medically needy income standard**
- ( ) **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- ( ) **The amount is determined using the following formula:**

Specify:

- ( ) **Other**

Specify:

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

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The state does not establish reasonable limits.**
- ○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ○ **The following formula is used to determine the needs allowance:**

Specify formula:

○ **Other**

Specify:

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

Select one:

◉ **Allowance is the same**
○ **Allowance is different.**

Explanation of difference:

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

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
◉ **The state does not establish reasonable limits.**
○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 2

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- (●) **By the operating agency specified in Appendix A**
- ( ) **By a government agency under contract with the Medicaid agency.**

Specify the entity:

○ **Other**
Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

An initial evaluation of a participant's Level of Care (LOC) is determined by a board certified physician/designee (nurse practitioner or physician's assistant who practices under the supervision and license of a board certified physician) who must evaluate the participant, then complete and sign the OCDD form 90-L.

The LGE staff that initially evaluate participants and issue a Statement of Approval (SOA) are required to meet the minimum qualifications as follows:

A baccalaureate degree in psychology; counseling; social work; sociology; criminal justice, nursing; public health; public health administration; public administration; hospital administration; education with twenty-four semester hours in psychology, special education or early childhood education; speech communications/pathology; physical therapy; occupational therapy; therapeutic recreation; music therapy; or family and consumer sciences (with a concentration in child, family and social services) followed by one year of professional level experience providing any of the following services: developmentally disabled services, alcohol/drug abuse counseling or treatment, mental health treatment, health care management, or social services.

The LGE staff, who are responsible for reviewing the initial LOC and approving initial plans of care, are required to meet, as a minimum, the following qualifications : A baccalaureate degree plus two years of professional level experience in hospital or nursing home administration, public health administration, social services, nursing, pharmacy, dietetics/nutrition, physical therapy, occupational therapy, medical technology, or surveying and/or assessing health or social service programs or facilities for compliance with state and federal regulations. A current valid Louisiana license in one of the qualifying fields will substitute for the required baccalaureate degree. A master's degree in one of the qualifying fields will substitute for a maximum of one year of the required experience.

The OCDD form 90-L is used in conjunction with the Statement of Approval (SOA) to initially determine a person's qualifications for Developmental Disabilities services and approve them for services according to the LOC determined in the discovery process.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The level of care criteria is based upon the following:

La. R.S. 28:451.2. Definitions:

"...(12) Developmental Disability means either:

(a) A severe chronic disability of a person that:

(i) Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments.

(ii) Is manifested before the person reaches age twenty-two.

(iii) Is likely to continue indefinitely.

(iv) Results in substantial functional limitations in three or more of the following areas of major life activity:

(aa) Self-care

(bb) Receptive and expressive language.

(cc) Learning.

(dd) Mobility.

(ee) Self-direction.

(ff) Capacity for independent living.

(gg) Economic self-sufficiency.

(v) Is not attributed solely to mental illness.

(vi) Reflects the persons need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

(b) A substantial developmental delay or specific congenital or acquired condition in a person from birth through age nine which, without services and support, has a high probability of resulting in those criteria in Subparagraph (a) of this Paragraph, later in life that may be considered to be a developmental disability.

The OCDD - form 90-L is used to determine the ICF/IID Level of Care. The individual's primary care physician or physician's designee (licensed advance nurse practitioner or licensed physician's assistant who practices under the supervision and license of a board certified physician) must complete, sign and date the 90-L. This form must be completed at initial evaluation and annually thereafter to determine if the individual still meets the ICF/IID level of care. The 90-L is used in conjunction with the Statement of Approval (SOA) to establish a level of care criteria and to complete the Plan of Care. SOA is a notification to an individual who has requested waiver services that it has been determined by the LGE they meet the developmental disability criteria (Developmental Disability Law- La. R.S. 28:451) for participation in programs administered by OCDD and that they have been placed on the OCDD Request for Services Registry for waiver services and their protected date of request. The 90-L, SOA and initial plan of care documents are submitted by the Support Coordination Agency to the LGE for staff review to assure that the applicant/participant meets/continues to meet the level of care criteria.

The Developmental Disability (DD) decision is made by the LGE utilizing the systems entry process. If the individual is determined to meet the DD criteria they are issued a Statement of Approval (SOA), if they do not meet the DD criteria they are issued a Statement of Denial (SOD). Individuals who receive a SOD are informed of their rights to appeal and are provided information regarding the appeals process. Please refer to Fair Hearings/Appeals process as outlined in Appendix F-section F-1 of the waiver document.

The LGE staff conduct a pre-certification home visit to verify accuracy of level of care for all initial evaluations only.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**

○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The Office for Citizens with Developmental Disabilities (OCDD) form 90-L is used to determine the ICF/DD Level of Care. The individual's primary care physician/designee (nurse practitioner or physician's assistant who practices under the supervision and license of the physician) must complete and sign and date the 90-L. This form must be completed at initial evaluation and annually thereafter to determine if the individual still meets the ICF/IDD level of care. The 90-L is used in conjunction with the Statement of Approval to establish a level of care criteria and to assist in completion of the plan of care. The 90-L, Statement of Approval and plan of care documents are submitted to the OCDD LGE for staff review to assure that the applicant/participant meets/continues to meet the level of care criteria. For Plans of Care approved by the Support Coordination supervisor, the 90-L, Statement of Approval, and Plan of Care are reviewed to assure the participant continues to meet the level of care criteria.

There is no difference in the process for the LOC evaluations and re-evaluations except that LGE staff conduct a pre-certification home visit to verify accuracy of level of care for all initial evaluations. Support Coordination Supervisors approve subsequent annual LOC evaluations as defined by OCDD's policy.

The Developmental Disability decision is made by the LGE staff utilizing the systems entry process. If the individual is determined to meet the DD criteria they are issued a Statement of Approval (SOA), if they do not meet the DD criteria they are issued a Statement of Denial (SOD). Individuals who receive a SOD are informed of their rights to appeal and are provided information regarding the appeals process. Please refer to Fair Hearings/Appeals process as outlined in Appendix F-section F-1 of the waiver document.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ○ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ◉ **The qualifications are different.**

  Specify the qualifications:

All support coordinator/case management supervisors must meet one of the following education and experience requirements:
1. A bachelor or master's degree in social work from a program accredited by the Council on Social Work Education and two years of paid post degree experience in providing Support Coordination services, or
2. a currently licensed Registered Nurse (RN) with at least two years of paid post degree experience or
3. A bachelor' or master's degree in a human service related field which includes; psychology, education, counseling, social services, sociology, philosophy, family and consumer sciences, criminal justice, rehab services, child development, substance abuse, gerontology, and vocational rehabilitation and two years of paid post degree experience in providing Support Coordination services; or
4. A bachelor's degree in liberal arts or general studies with a concentration of at least 16 hours in one of the fields listed in item 3 of this part and two years of paid post degree experience in providing Support Coordination services.

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

The Medicaid Data Contractor has edits in the database system for tracking to ensure timely re-evaluations for the level of care.

When the LGE or Support Coordination agency sends an approved Plan of Care to the Medicaid data contractor, the information contains the date of the 90Lwhich is the date of the physician/nurse practitioner's/ physician's assistant signature. This date is tracked in the data contractor's database for every POC. The 90L date is compared to the POC begin date to determine if the reevaluation was timely performed. The database generates a report which is shared with OCDD. LGEs, Support Coordination and BHSF.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records of level of care are maintained by the LGE and in the physical office of the Support Coordination Agency.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

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

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

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

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

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B.a.i.a.1. Number and percentage of initial waiver applicants who have been determined to meet the ICF/ID level of care prior to waiver certification. Percentage = Number of initial applicants in the sample who were determined to have met the level of care determination criteria /Number of initial applicants reviewed in the sample.

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

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

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

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

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

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

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

Performance Measure:
B.a.i.c.2 Number and percentage of initial waiver applicants level of care evaluation

determined to be accurate according to the State's procedures. Percentage: Number of initial waiver applicants with level of care evaluations determined to be accurate/Total number of initial waiver applications reviewed in the sample.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
B.a.i.c.1. Number and percentage of initial applicants who's LOC has been completed following state procedures. Percentage = Number of initial applicants who's LOC determination has been completed following state's procedures/Total number of completed initial LOC determinations reviewed in the sample.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure B.a.i.a.1, B.a.i.c.1 and B.a.i.c.2: The LGE office reviews all initial applications to ensure that they contain all required information needed to confirm the LOC determination. Any incomplete, untimely, or inaccurate applications are returned by theLGE staff to the support coordinator for correction/clarification. The LGE staff will submit written documentation outlining the reason for the return to the support coordinator. If the system entry eligibility is questioned by the LGE staff as a result of the face to face visit, then the LGE system entry staff will be contacted to ascertain if eligibility re-determination is required.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on

the methods used by the state to document these items.

Performance Measures B.a.i.a.1, B.a.i.c.1, B.a.i.c.2:

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

On a quarterly basis at the OCDD State Office (SO) level, remediation data is aggregated and reviewed by the Program Manager to assure that all cases needing remediation are addressed. If adverse trends and patterns are identified, then recommendations are made by the Program Manager to the OCDD SO Quality Enhancement Section for review and corrective action, if needed, with the specific LGE. If the adverse trends and patterns identified are systemic in nature (across more than one LGE), then the Program Manager will forward the item to the Performance Review Committee for review and corrective action assignment.

A variety of mechanisms are employed by BHSF/MPSW to ensure all remediation and appropriate action has been completed:
•MPSW reviews the quarterly aggregated quality reports and remediation reports provided by the operating agency to ensure all instances of non-compliance are remediated within 30 days of notification.
•MPSW meets with OCDD State Office agency staff on a quarterly basis to discuss delegated functions, pending issues, and remediation plans. Systemic issues requiring remediation are will be identified and discussed at the Cross-Waiver (which includes staff from MPSW, OAAS, and OCDD) and Medicaid Oversight Review Team (which includes Medicaid staff) meetings. A plan for remediation and person responsible will be is developed and person responsible is assigned for each item identified. Remediation strategies and progress towards correction will be are reviewed and documented at the next scheduled meeting until the item is closed out.
•MPSW, the Medicaid Director or Deputy Director, the OCDD Assistant Secretary, and other pertinent staff meet on at least a quarterly basis to discuss any pending issues and remediation plans.
•Memorandums are sent from BHSF to OCDD to ensure all necessary leadership is informed of the support actions needed to correct problems or make improvements.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

The Louisiana Department of Health, 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	Adult Day Health Care		
Statutory Service	Day Habilitation		
Statutory Service	Monitored In Home Caregiving		
Statutory Service	Prevocational Services		
Statutory Service	Respite Services - Out of Home		
Statutory Service	Shared Living Services		
Statutory Service	Support Coordination		
Statutory Service	Supported Employment		
Extended State Plan Service	Assistive Technology/Specialized Medical Equipment and Supplies		
Supports for Participant Direction	Financial Management Services		
Other Service	Community Life Engagement Development		
Other Service	Community Living Supports		
Other Service	Companion Care		
Other Service	Dental Services		
Other Service	Environmental Accessibility Adaptations		
Other Service	Host Home		
Other Service	Housing Stabilization Service		
Other Service	Housing Stabilization Transition Service		
Other Service	Nursing		
Other Service	One-Time Transitional Services		
Other Service	Personal Emergency Response System		
Other Service	Professional Services		
Other Service	Transportation-Community Access		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Health Care

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Services furnished as specified in the plan of care at an ADHC center, in a non-institutional, community-based setting encompassing both health/medical and social services needed to ensure the optimal functioning of the participant.

Adult Day Health Care Services include:
- Meals - shall not constitute a “full nutritional regimen” (3 meals per day) but shall include a minimum of 2 snacks and a hot nutritious lunch.
- Transportation between the participant's place of residence and the ADHC in accordance with licensing standards;
- Assistance with activities of daily living;
- Health and nutrition counseling;
- Individualized exercise program;
- Individualized goal-directed recreation program;
- Health education classes; and
- Individualized health/nursing services.

The number of people included in the service per day depends on the licensed capacity and attendance at each facility; the average capacity is 49.

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

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

ADHC services may be provided no more than 10 hours per day and no more than 50 hours per week

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Care

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Adult Day Health Care

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Must be enrolled as a Medicaid ADHC provider

Must comply with LDH rules and regulations

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

Verification of Provider Qualifications

Entity Responsible for Verification:

LDH Health Standards Section

Frequency of Verification:

Initial and periodically as deemed necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04070 community integration
Category 2:	**Sub-Category 2:**
04 Day Services	04020 day habilitation
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Day habilitation services focus on the person centered planning process, which would allow the participant a choice in how they spend their day. 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 to be limited to a fixed- site. 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 activities should be educational or recreational in nature, which would include activities that are related to the individual's interests, hobbies, clubs, or sports. For individuals with degenerative conditions, day habilitation may include training and supports designed to maintain skills and functioning and to slow or prevent regression rather than acquiring new skills or improving existing skills. Day Habilitation Services may be coordinated with needed therapies in the individual's person centered Plan of Care. The individual of retirement age may also be supported in senior community activities or other meaningful retirement activities in the community, such as the local council on aging or senior centers. 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. Day habilitation may not provide for the payment of services that are vocational in nature – for example, the primary purpose of producing goods or performing services.

Transportation services (including wheelchair) 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.

Assistance with personal care may be a component part of day habilitation services as necessary to meet the needs of a participant, but may not comprise the entirety of the service.

Volunteer activities should be provided under the guidelines of the United States Fair Labor Standards Act of 1985 as amended.

Day Habilitation can be delivered in 3 separate delivery methods:

1.Onsite Day Habilitation(ODH) is typically delivered in a ratio of 1:8. Services can be delivered onsite inside of a day program building.This service should focus on the person centered planning process, which allows the participant a choice in how they spend their day and should take into account the how their time is spent when using Community Life Engagement services. ODH activities should be consistent with the individual's interests, skills and desires and should assist the participant to gain their desired meaningful day. ODH can be offered in a variety of community settings, (i.e. local recreation department, garden clubs, libraries). The community should be a regular part of ODH activities including volunteers and community partnerships and engagement. However, the use of 'reverse integration' does not supplant the inclusion of community life engagement.

2.Community Life Engagement (CLE) is delivered in a small group of 1-2/4 or 1:1. When planning for this service, the Person Centered Planning Process should be used for each person to develop a plan for how they want to engage in their community including the frequency and activities.

CLE refers to services that help support individuals with disabilities to access and participate in purposeful and meaningful activities in their communities. The role of CLE varies depending on the particular needs of the individual. This service promotes opportunities and support for community inclusion; building interests and developing skills and potential for not only meaningful community engagement but also it can help the individual in figuring out areas of interests for possible competitive integrated employment in the community. Services should be completed in the community in small groups of 2 to 4 or 1:1 individuals, which allows for a more person centered planning of activities. Services should result in active, valued participation and engagement in a broad range of integrated activities that build on the participant's interests, preferences, gifts, and strengths while reflecting his or her desired outcomes related to community involvement and membership. This service involves participation in integrated community settings, in activities that include persons without disabilities and with people who are not paid or unpaid caregivers. This service is expected to result in the individual developing and maintaining social roles and relationships; building natural supports; increasing independence; increasing potential for employment and/or experiencing meaningful community participation and inclusion. Volunteering is expected to be a part of this service as well.

Requirements:

•Use an approved activity log to document activities done in the community

•Electronic Visit Verification must be utilized

•Services may be delivered during the days and times that activities are available. There are no limits to the days or times. Services can be delivered during the day, evenings and/or weekends.

•CLE cannot be delivered at the same time as any other service.

3. Virtual Delivery of Day Habilitation(VDDH) should be delivered in a 1:8 ratio and should be person centered and tailored to the interest and needs of each person much like the in person services. VDDH service is intended to provide opportunities for individuals to interact and receive services through an online format where face-to-face

interaction can occur that is in line with their expectations for a meaningful day. VDDH service is meant to keep an individual engaged with peers and the community during times where the individual is unable to interact in person, such as during a pandemic or state of emergency or when an individual is unable to attend in-person activities such as events due to medical situations that will keep them from receiving services in-person.
VDDH is a delivery method with the same components and scope as in-person Day Habilitation services with the exception of the transportation component. Selection of in-person versus virtual delivery of this service will be based on the beneficiary's choice and needs. The percentage of time used in virtual delivery will be determined by each beneficiary's choice and needs.
VDDH services will be facilitated by the provider agency who will continue to incorporate already established community partners into the VDDH. Providers will seek opportunities for beneficiaries to join community online groups and seek out such activities as online church services and groups, exercise classes, cooking and drawing classes. Through virtual delivery of this service, beneficiaries can continue to interact with their friends and community connections during the times when in person services are not taking place. Providers will encourage beneficiaries to attend in person community activities of their choice to facilitate and increase community integration. VDDH will be utilized during times that do not allow for the beneficiary to attend in person (i.e.medical issues/surgery), an emergency situation where a provider agency may be closed or when the beneficiary might choose to not attend in person for personal reasons. Virtual delivery is not the typical delivery method. The beneficiary must be independent or have natural supports as this service cannot be billed at the same time as another service. The beneficiary must have the means necessary to participate in the virtual service. VDDH is not preferred as beneficiarys are encouraged to participate in the community. VDDH will be discussed with each beneficiary by the support coordinator and will be included in the plan of care if chosen.All VDDH services must be approved by the Local Governing Entity or the OCDD State Office and should be delivered as outlined in the OCDD Policy and Procedures manual. An initial assessment of beneficiary, home, HIPAA compliance prior to beginning virtual services. Providers will receive written instructions on the delivery of virtual services based on the HIPAA compliance officer's instructions.
When using virtual delivery, providers will follow these guidelines:
•Confidentiality still applies for services delivered through virtual delivery. The session must not be recorded without consent from the beneficiary or authorized representative.
•Develop a back-up plan (e.g., phone number where beneficiary can be reached) to restart the session or to reschedule it, in the event of technical problems.
•Develop a safety plan that includes at least one emergency contact and the closest ER location, in the event of a crisis.
•Verify beneficiary's identity, if needed.
•Providers need the consent of the beneficiary and the beneficiary's parent or legal guardian (and their contact information) prior to initiating a telemedicine/telehealth service with the beneficiary if the beneficiary is 18 years old or under.
•The beneficiary must be informed of all persons who are present and the role of each person.
•Beneficiaries may refuse services delivered through telehealth.
•It is important for the provider and the beneficiary to be in a quiet, private space that is free of distractions during the session
Beneficiaries are instructed to find a space out of their bedroom that allows for privacy while participating in the service delivery of virtual day habilitation. Beneficiaries are instructed to turn their camera off and mute the session if they leave to go to the bathroom or if someone who is not part of the group comes into the room. Providers will ensure the beneficiaries understand the guidelines for participation in the virtual service. Written instructions will be provided to each beneficiary.
The provider will instruct the beneficiary/natural support to understand how to utilize the technology required to participate in the virtual delivery of day habilitation, including how to utilize the specific format, signing in and out. The provider will provide written instructions.
If the beneficiary is able to be unsupported during this service, an existing protocol is in place for the person if a health and safety issue arises during this virtual service.The provider agency staff, who is conducting the virtual delivery of this service, will be able to support the beneficiary through any health and safety situation that might arise during the virtual day habilitation service time. If the beneficiary is participating in virtual services with the assistance of natural supports, the natural supports will ensure the health and safety of the beneficiary.
Minimum Requirements for VDDH:
•Must utilize a format that allows for face-to-face interaction
•Must be approved by LGE based off the criteria as outlined in the OCDD policy and procedures manual.
•Must utilize EVV to check in and out of VDDH
•Must utilize an approved Activity Log to track the days, times and activities that the participant is utilizing VDDH

Day Habilitation Services may be coordinated with needed therapies in the individual's person-centered Plan of Care.
The Day Habilitation provider is responsible for all transportation between day habilitation sites. Time spent in transportation between the participants residence/location and the day habilitation site is not to be included in the total number of day habilitation services hours per day, except when the transportation is for the purpose of travel training. Travel training must be included in the participants Plan of Care.

Day Habilitation Services may be coordinated with needed therapies in the individual's person-centered Plan of Care.
The Day Habilitation provider is responsible for all transportation between day habilitation sites. Time spent in transportation between the participants residence/location and the day habilitation site is not to be included in the total number of day habilitation services hours per day, except when the transportation is for the purpose of travel training. Travel training must be included in the participants Plan of Care.

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

Services shall be furnished on a regularly scheduled basis, for up to 8 hours, one or more days per week based on a 15 minute unit of service. Any time less than 15 minutes of service is not billable or payable. No rounding up of units is allowed.

Cannot be billed for at the same time on the same day as Community Living Supports, Respite-Out of Home, Prevocational Services, Supported Employment, Adult Day Health Care or Monitored in Home Care Giving (MIHC).

Cannot be billed for at the same time on the same day as Professional services except when there are direct contacts needed in the development of a support plan.

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 Care Center

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 Care Center

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Department of Health (LDH) (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:

Live-in Caregiver (42 CFR §441.303(f)(8))

Alternate Service Title (if any):

Monitored In Home Caregiving

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

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

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

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

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

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

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

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

Participants electing Monitored In-Home Caregiving are not eligible to receive the following Residential Options Waiver services: Community Living Supports (CLS), Companion Care Supports, Host Home, or Shared Living Supports during the period of time the participants is receiving Monitored In-Home Caregiving.

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	Monitored In Home Caregiving

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Monitored In Home Caregiving

Provider Category:

Agency

Provider Type:

Monitored In Home Caregiving

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Must enroll as a Medicaid Monitored In-Home Caregiving provider. Must comply with LDH rules and regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Standards Section

Frequency of Verification:

Initial and as deemed necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
03 Supported Employment	03030 career planning
Category 3:	**Sub-Category 3:**
04 Day Services	04010 prevocational services
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Prevoc Services(PV) also referred to as Career Planning (CP) services, are designed to create a path to integrated, individual,community-based employment for which an individual is compensated at or above min wage, but not less than the customary wage & level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.Good candidates for PV services may include individuals who want to work but may not be sure where their interests lie & need to explore further options. CP is not a required pre-requisite for individual SE services & at any time during this service, one may choose to leave it either because they want to go to work immediately or because they are no longer interested in working. PV service is best completed in the community & in practical situations,but there are some options for activities that can be completed onsite. PV service should be delivered in the community utilizing locations such as businesses,Workforce Job Centers & other places that can assist the individual in developing skills & competencies necessary for an individual to be employed in a competitive job. A variety of career exploration activities such as individual discovery activities, career education, career assessments & financial education should occur during this service. Activities that could occur include volunteering, internships & mentoring. The outcome of this service should be a personal career profile & will provide valuable information for the next phase of the career path. CP services may be provided in a variety of settings including home visits conducted as part of individual discovery & getting to know the individual in their day to day life.PV Services assist beneficiaries in acquiring &maintaining basic work-related skills necessary to retain competitive employment with the goal of independent employment & career options within the community. Participants receiving these services MUST have an employment related goal as part of their future Plan of Care (POC).PV Services may be delivered onsite,in smaller work groups with career planning as well as Virtual Delivery (VD)of PV Services. This will increase participation while catering to the wants & needs of beneficiary's goals for gainful employment.

Transportation services(including wheelchair)are offered & billable as a component of PV Services.Transportation may be provided to &/or from participant's residence or a location agreed upon by participant or AR. PV provider is responsible for all transportation between PV/Community CP sites. Transportation is only provided on the day a PV service is provided.Transportation is billed as a separate services in 2 one-way trips per day, typically from the home to the PV Site. Time spent in transportation between participant's residence/location & PV site is not to be included in total number of PV services hours per day, except when the transportation is for the purpose of travel training. Travel training must be included in the participant's POC.

PV service is a time limited service as defined in OCDD policy& procedures manual & a targeted service for people wanting to become employed but may need additional information & experiences in order to determine such things as their areas of interests for work, skills and strengths & conditions needed for successful employment. Assistance with personal care may be a component of PV services, but may not comprise the entirety of service.

PV SERVICES can be delivered in 3 separate delivery methods.

1. Onsite PV Services also referred to as onsite CP services can be delivered in a 1:8 ratio. Services are intended to support tindividual in developing general, non-job-task-specific strengths & skills that contribute to employability in paid employment in integrated community settings. Examples include: how to communicate effectively with supervisors, co-workers, &customers; accepted community workplace conduct & dress; attention to tasks & directions; workplace problem solving skills & general workplace safety & mobility training. Onsite Services could consist of activities such as: making contact with businesses & research via the internet opportunities for career options through internships, mentoring opportunities &volunteer positions. Community exploration & business tours can also be completed to assist in determining a direction for employment. Career exploration & discovery activities should be part of service. Service should be individualized &should be used in the development of a career plan 'profile' for each person. Assistance with personal care may be a component of PV services, but may not comprise the entirety of service.

Onsite (CP) services should consider the community CP services & should work together to accomplish the goals set forth.

2. Community CP is delivered in a small group with a ratio of 1:2-4 or 1:1 is an individualized, person-centered, comprehensive service that assists individuals in establishing their path to obtain individual, competitive integrated employment in the community. Outcome of service is to create a 'Profile' for each person that can be utilized to create their employment plan.

CP Services are designed to create a path to individual, integrated community based employment for which an individual is compensated at or above min wage, but not less than the customary wage & level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. CP services are intended to use PCP process to discover the various interest, skills & general information about each person that will assist in developing a path to employment in the community. Based off the PCP, activities should be tailored for each person in preparing them for paid employment in the community. Individuals can leave CP at any time to pursue employment or if they decide they do not want to pursue employment at this time. Participation in CP is not a requirement in order for the individual to go to work.

3. VD PV services should be person centered & tailored to the interests & needs of each person & should provide opportunities & support for individuals to interact & receive services through an online format where interaction face to face can occur. VD PV service is meant to work on individual goals specific to each person going to work. Services are meant to increase the knowledge & info related to employment. All activities should be centered on creating a 'profile' that will support the goal of individual community employment. Services are meant to keep an individual engaged with peers & the community during times where individuals are unable to interact in person, such as during a pandemic or state of emergency or when someone will be unable to join in person due to medical situations that will keep them from receiving services in person. VD PV service should receive approval from the LGE. VD PV Service is a delivery method with the same components & scope as in-person PV services with the exception of the transportation component. Selection of in-person versus VD PV service will be based on the beneficiary's choice & needs. The percentage of time used in VD will be determined by each beneficiary's choice & needs.

VD PV will be utilized during times that does not allow for the beneficiary to attend in person (i.e. medical issues/surgery), an emergency situation where provider may be closed or when the beneficiary might choose to not attend in person for personal reasons. Beneficiary must be independent or have natural supports as this service cannot be billed at the same time as another service. Beneficiary must have the means necessary to participate in the virtual service, (i.e. laptop, tablet, etc.). VD PV is not the preferred method as beneficiaries are encouraged to participate in the community through either onsite PB or Community CP services. Service will be discussed with each beneficiary by the support coordinator and will be included in the POC if chosen.

Initial assessment of beneficiary, job site, HIPAA compliance prior to beginning virtual services. Providers will receive written instructions on the delivery of virtual services based on the HIPAA compliance officer's instructions.

When using VD PV, providers are expected to follow these guidelines:

•Confidentiality still applies for services delivered through VD. Session must not be recorded without consent from beneficiary or AR. Develop a back-up plan (e.g., phone number where beneficiary can be reached) to restart the session or to reschedule it, in the event of technical problems.

•Develop a safety plan that includes at least one emergency contact & the closest ER location, in the event of a crisis.

•Verify beneficiary's identity, if needed.

•Providers need the consent of beneficiary and beneficiary's parent or legal guardian (& their contact information) prior to initiating a telemedicine/telehealth service with beneficiary if beneficiary is 18 years old or under.

•Beneficiary must be informed of all persons who are present & the role of each person.

•Beneficiaries may refuse services delivered through telehealth.

•It is important for the provider & beneficiary to be in a quiet, private space that is free of distractions during the session

Beneficiaries are instructed to find a space outside of their bedroom that allows for privacy while participating in the service delivery of VD PV services. Beneficiaries are instructed to turn their camera off & mute the session if they leave to go to the bathroom or if someone who is not part of the group comes into the room. Providers will ensure beneficiaries understand the guidelines for participation in the virtual service. Written instructions will be provided to each beneficiary.

VD PV services will be facilitated by the provider, who will continue to incorporate already established community partners into the VD PV services. This could be already established volunteer group, internship or mentorship. Providers will also seek opportunities for beneficiaries to join community online groups & seek out career preparation activities. Also, through VD PV of this service, beneficiaries can continue to interact with those that they are working with to continue working on their path to employment which might include job exploration & discovery sessions. Providers will encourage beneficiaries to attend in person community activities of their choice to facilitate & increase community integration. Providers will instruct the beneficiary/natural support in how to utilize the technology required to participate in the VD PV services including how to utilize the specific format, signing in and out. Providers will provide a copy of written instructions for beneficiary to refer to & beneficiary will always be able to call provider for assistance.

If the beneficiary already has unsupported time, there is an existing protocol in place for the person if a health & safety issue arises during the VD PV. Provider staff, who is conducting the VD PV service, will be able to support beneficiary through any health & safety situation that might arise during the VD PV service time. If beneficiary is participating in VD with the assistance of natural supports, natural supports will ensure the health &safety of the beneficiary.

Requirements For Virtual:

•Must utilize some type of format that allows for face to face interaction

•Must be approved by LGE based off the criteria as outlined in the OCDD Policy & procedures manual.

•Must utilize EVV to check in & out of VCP

•Utilize Activity Log to track the activities, days &times that participant is utilizing VCP
•This service cannot be used at the same time as any other service on the same day.

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

Services shall be furnished on a regularly scheduled basis, for up to 8 hours per day, one or more days per week based on a unit of service. The participant must spend the 15-minute unit of service at the service site. Any time less than 15 minutes of service is not billable or payable. No rounding up of units is allowed.
Cannot be billed for at the same time on the same day as other services.
Cannot be billed for at the same time on the same day as Professional services except when there are direct contacts needed in the development of a support plan.
Prevocational Services are not available to individuals who are eligible to participate in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (26) and (29) of the Individuals with Disabilities Education Act, 20 U.S.C. 1401 (16) and (71).
Through special permission from the Local Governing Entity and under special circumstances as outlined in the OCDD Policy and Procedures manual, a person can complete this service more than once.

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 Care

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:

Adult Day Care

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Department of Health (LDH) (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:

Respite

Alternate Service Title (if any):

Respite Services - Out of Home

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Respite Services-Out of Home is provided on a short-term basis to participants who are unable to care for themselves due to the absence of or need for relief of caregivers who normally provide care and support. Services are provided by a Center-Based Respite provider.

Federal Financial Participation will be claimed for the cost of room and board only if it is provided as part of respite care furnished in a respite center approved by the State that is not a private residence.

Community activities and transportation to and from these activities in which the participant typically engages in are to be available while receiving Respite Services-Out of Home. These activities should be included in the participant's approved Plan of Care. This will provide the participant the opportunity to continue to participate in typical routine activities. Transportation costs to and from these activities are included in the Respite Services-Out of Home rate.

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

Respite Services-Out of Home are limited to 720 hours per Plan of Care year. The process for approving hours in excess of 720 hours must go through the established approval process with proper justification and documentation.

Cannot be provided in a personal residence

Respite Services-Out of Home is not a billable waiver service to participants receiving the following services:
- Community Living Supports
- Companion Care
- Host Home
- Shared Living

Payment will not be made for:
- Transportation-Community Access

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	Center-Based Respite Care

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Services - Out of Home

Provider Category:

Agency

Provider Type:

Center-Based Respite Care

Provider Qualifications

License *(specify):*

Providers must be licensed by the Louisiana Department of Health as a home and community-based services provider and meet the module requirements for Center-Based Respite.
LAC 48:1.Chapter 50

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Department of Health (LDH)(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):

Shared Living Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

Shared Living services are provided to a participant in his/her home and community to achieve, improve, and/or maintain social and adaptive skills necessary to enable the participant to reside in the community and to participate as independently as possible.
Shared Living services focus on the participant's preferences and goals. Supports provided are related to the acquisition, improvement, and maintenance in level of independence, autonomy, and adaptive skills and are to be included in each participant's Plan of Care. This includes self-care skills, adaptive skills, and leisure skills with the overall goal of providing the participant the ability to successfully reside with others in the community while sharing supports. Shared Living services take into account the compatibility of the participants sharing services which includes individual interests, age of the participants, and the privacy needs of each participant. Each participant's essential personal rights of privacy, dignity and respect, and freedom from coercion are protected.

The Shared Living setting is selected by each participant among all available alternatives and identified in each participant's Plan of Care. Each participant has the ability to determine whether or with whom they share a room. Each participant has the freedom of choice regarding daily living experiences which includes meals, visitors, and activities. Each participant is not limited in opportunities to pursue community activities.
Shared Living services may be shared by up to four participants who have a common Shared Living provider agency.
Shared Living services must be agreed to by each participant and the health and welfare must be able to be assured for each participant. If the person has a legal guardian, their approval must also be obtained. Each participant's Plan of Care must reflect the Shared Living services and include the shared rate for the service indicated.

The Shared Living service setting is integrated in, and facilitates each participant's full access to the greater community, which includes opportunities for each participant to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, like individuals without disabilities.
Shared Living service providers are responsible for providing 24-hour staff availability along with other identified responsibilities as indicated in each participant's individualized Plan of Care. This includes each participant's routine daily schedule and ensuring the health and welfare of each participant while in their place of residence, community and for any other waiver services provided by the Shared Living services provider.
Shared Living services may be provided in a residence that is owned or leased by the provider or that is owned or leased by the participant. Services may not be provided in a residence that is owned or leased by any legally responsible relative of the participant. If Shared Living services are provided in a residence that is owned or leased by the provider, any modification of the conditions must be supported by specific assessed needs and documented in the participant's Plan of Care. The provider is responsible for the cost of and implementation of the modification when the residence is owned or leased by the provider.
In a provider-owned or controlled residential setting, the following additional conditions must be met. Any modifications of the conditions must be supported by a specific assessed need and documented in the Plan of Care:

- The unit or room is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the participant receiving services, and the participant has, at a minimum, the same responsibilities and protections from eviction that the tenants have under the landlord/tenant laws of the state, parish, city, or other designated entity.
- Each participant has privacy in their sleeping or living unit which includes:
  - Units have lockable entrance doors, with appropriate staff having keys to doors;
  - Participants share units only at the participant's choice; and
  - Participants have the freedom to furnish and decorate their sleeping or living units;
- Participants have the freedom and support to control their own schedules and activities, and have access to food at any time;
- Participants are able to have visitors of their choosing at any time; and
- The setting is physically accessible to the participant.

The Shared Living services rate includes the cost of transportation. The provider is responsible for providing transportation for all community activities except for vocational services. Transportation for vocational services is included in the rate of the vocational service.

All Shared Living service participants are required to have an individualized back-up staffing plan and an individualized emergency evacuation plan which are to be submitted with their Plan of Care.

Shared Living services are not located in a building that is a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or disability-specific housing complex. Shared Living services are not provided in settings that are isolated from the larger community.
Family members who provide Shared Living services must meet the same standards as unrelated provider agency staff.

ICF/ID providers who convert an ICF/ID to an SL via the shared living conversion model must be approved by OCDD and licensed by HSS prior to providing services in this setting, and prior to accepting any ROW participant or applicant for residential or any other developmental disability service(s).

An ICF/ID provider who elects to convert to an SIL via the shared living conversion process shall obtain the approval of all of the residents of the home(s) (or the responsible parties for these residents) regarding the conversion of the ICF/ID prior to beginning the process of conversion.

ICF/ID providers who elect to convert to an SL via the shared living conversion process shall submit a licensing application for a HCBS provider license, SL Module.

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

Shared Living services aren't available to participants 17 and under.

All Medicaid State Plan nursing services must be utilized and exhausted.
Payment will not be made for services provided by a relative who is a:

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

The Shared Living staff may not live in the participant's place of residence.
Payment does not include room and board or maintenance, upkeep and improvement of the participant's or provider's property.
Payment will not be made for the following services:

- Community Living Supports
- Companion Care
- Host Home
- Respite Care Services-Out of Home
- Transportation-Community Access
- Environmental Accessibility Adaptations (if housing is leased or owned by the provider)
- or Monitored in Home Care giving (MIHC)

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	Shared Living

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Shared Living Services

Provider Category:

Agency

Provider Type:

Shared Living

Provider Qualifications

License *(specify):*

Providers must be licensed by the Louisiana Department of Health as a home and community-based services provider and meet the module requirements for Supervised Indedepent Living and/or Supervised Independent Living-Conversion.
LAC 48:1.Chapter 50

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Department of Health (LDH) (Health Standards Section)

Frequency of Verification:

Initially, annually and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Support Coordination

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Support Coordination services are provided to all participants to provide assistance in gaining access to needed waiver services, Medicaid State Plan services, as well as needed medical, social, education, and other services, regardless of the funding source for the services. Support Coordination services includes assistance with the selection of service providers, development/revision of the Plan of Care, and monitoring of services.

When participants choose to Self-Direct services, Support Coordination services provide information, assistance, and management of the service being Self-Directed. This includes assisting the participant in reviewing, understanding, and completing the activities as identified in the Self-Direction Employer Handbook. The handbook includes information and procedures related to the participant's employer activities necessary for self-employment of services. Specific activities the Support Coordination services assists with include recruitment techniques, interviewing strategies, verification of employee qualifications, hiring of staff, staff scheduling, time sheet documentation, staff duties, employee performance evaluation, and termination of staff. Support Coordination services includes on-going support and assistance to the participant.

ROW will utilize support coordination for assisting with the moving of individuals from the institutions; up to ninety consecutive days or per LDH policy, but not to exceed 180 days will be allowed for transition purposes. Payment will be made upon certification and may be retroactive no more than ninety days or per LDH policy, but not to exceed 180 days prior to certification date.

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

OCDD Supports and Services Centers are prohibited from providing Case Management/Support Coordination services in the Residential Options Waiver (ROW).

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Support Coordination

Provider Category:

Agency

Provider Type:

Case Management

Provider Qualifications

License *(specify):*

Case Management
LAC 48:1 Chapter 49 (8/20/94)

Certificate *(specify):*

Other Standard *(specify):*

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

Case Manager and Case Manager Supervisor Qualifications: Must meet the following:

1. Bachelor or Master Degree in social work from a program accredited by the Council on Social Work Education; or
2. a currently licensed registered nurse (RN); or
3.a bachelor or master degree in a human service field which includes; psychology, education, counseling, social services, sociology, philosophy, family and consumer sciences, criminal justice, rehabilitation services, child development, substance abuse, gerontology, and vocational rehabilitation; or
4.a bachelor in liberal arts or general studies with a concentration of at least 16 hours in a human service field which includes; psychology, education, counseling, social services, sociology, philosophy, family and consumer sciences, criminal justice, rehab services, child development, substance abuse, gerontology, and vocational rehabilitation

Case Management Supervisor qualifications include an additional two years of paid post degree experience in providing case management services.
1. a bachelor's or master's degree in social work from a program accredited by the Council on Social Work Education and two years of paid post degree experience in providing support coordination services; or
2. a currently licensed registered nurse with at least two years of paid nursing experience; or
3. a bachelor's or master's degree in a human service related field which includes psychology, education,
counseling, social services, sociology, philosophy, family and consumer sciences, criminal justice, rehabilitation services, child development, substance abuse, gerontology, and vocational rehabilitation and two years of paid post degree experience in providing support coordination services; or
4. a bachelor's degree in liberal arts or general studies with a concentration of at least 16 hours in one of the fields listed in #3 and two years of paid post degree experience in providing support coordination services.

All training as identified and mandated by LDH is required in addition to the following: Orientation and Training for New Employees
New Staff Orientation
Orientation of at least sixteen (16) hours must be provided to all staff, volunteers, and students within five (5) working days of employment
A minimum of eight (8) hours of the orientation training must cover orientation to the target population including, but not limited to, specific service needs and resources

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

Training for New Staff
In addition to the required sixteen (16) hours of orientation, all new employees with no documented training must receive an additional minimum sixteen (16) hours of training during the first ninety (90) calendar days of employment
Training must be related to the target or waiver populations to be served and include specific knowledge,

skills, and techniques necessary to provide case management to the target or waiver populations
Training must be provided by an individual with demonstrated knowledge of both the training topics and the target or waiver populations
This training must include at a minimum the following: Assessment techniques
Support and service planning

Support and service planning for people with complex medical needs, including information on bowel management, aspiration, decubitus, nutrition
Resource identification Interviewing and interpersonal skills
Data management and record keeping Cultural awareness
Personal outcome measures

A new employee may not be given case management responsibility until the orientation is satisfactorily completed.
NOTE: Routine supervision may not be considered training.

Annual Training
It is important for case managers to receive continuing training to maintain and improve skills. Each case manager must satisfactorily complete twenty (20) hours of case-management related training annually which may include training updates on subjects covered in orientation and initial training. Case managers' annual training year begins with the date of hire.

The sixteen (16) hours of training for new staff required in the first ninety (90) days of employment may be part of the twenty (20) hour minimum annual training requirement. Appropriate updates of topics covered in orientation and training for a new case manager must be included in the required twenty (20)hours of annual training.

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

Training for Supervisors
Each case management supervisor must complete a minimum of forty (40) hours of training a year. In addition to the required and suggested topics for case managers, the following are suggested topics for supervisory training:
Professional identification/ethics
Process for interviewing, screening, and hiring of staff Orientation/in service training of staff
Evaluating staff Approaches to supervision Managing caseload size Conflict resolution Documentation
Time management

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Department of Health (LDH) (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:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 3:	**Sub-Category 3:**
03 Supported Employment	03022 ongoing supported employment, group
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Supported Employment is competitive work in an integrated work setting, or employment in an integrated work setting in which the participant is working toward competitive work, consistent with strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice with ongoing support services for whom competitive employment has not traditionally occurred. Supported Employment services are provided to participants who are not currently being served by Louisiana Rehabilitation Services or through a local education agency under IDEA and who might need follow along services. Some examples of Supported Employment are:

3. Individual placement and follow along services: An employment specialist (job coach) assists a person in locating individual competitive employment in the community and provides the training and supports necessary to obtain the job skills and also provides, the necessary ongoing follow along services on the to maintain employment. Micro-enterprise. This assistance consists of: (a) assisting the participant to identify potential business opportunities; (b) assistance in the development of a business plan, including potential sources of business financing and other assistance related to developing and launching a business; (c) identification of the supports that are necessary for the participant to operate the business; and, (d) ongoing assistance, counseling and guidance once the business has been launched.

4. Group Employment can be provided in a 1:8 ratio where individuals work in the community performing a job similar to individuals without disabilities. Typical group employment can be performed at a variety of locations throughout the community or at a business where individuals work throughout the business performing various work duties.

5. Virtual Delivery of Individual Follow Along Services are delivered in a 1:1 ratio. These services are delivered based on the already determined amount of follow along services necessary for the individual to maintain their employment. Specific circumstances should be present for Virtual Delivery follow-along services to occur and those services are defined in the OCDD Policy and Procedures manual.
In all circumstances, the employer/supervisor and the individual must be in agreement with a virtual Supported Employment visit and if the individual needs a means to conduct the virtual Supported Employment visit, the employer/supervisor must be willing to assist the individual in doing a virtual Supported Employment visit if the individual requires assistance. The visit should be coordinated with the employer/supervisor and the individual.

All virtual delivery of SE services must be approved by the Local Governing Entity or the OCDD State Office Staff.

Virtual Delivery of Supported Employment Service is a delivery method with the same components and scope as in-person Supported Employment services with the exception of the transportation component. Selection of in-person versus virtual delivery of this service will be based on the beneficiary's choice and needs. The percentage of time used in virtual delivery will be determined by each beneficiary’s choice and needs.

Providers will receive written instructions on the delivery of virtual services based on the HIPAA compliance officer’s instructions.
When using virtual delivery, providers are expected to follow these guidelines:
- Confidentiality still applies for services delivered through virtual delivery. The session must not be recorded without consent from the beneficiary or authorized representative.
- Develop a back-up plan (e.g., phone number where beneficiary can be reached) to restart the session or to reschedule it, in the event of technical problems.
- Develop a safety plan that includes at least one emergency contact and the closest ER location, in the event of a crisis.
- Verify beneficiary’s identity, if needed.
- Providers need the consent of the beneficiary and the beneficiary’s parent or legal guardian (and their contact information) prior to initiating a telemedicine/telehealth service with the beneficiary if the beneficiary is 18 years old or under.
- The beneficiary must be informed of all persons who are present and the role of each person.
- Beneficiaries may refuse services delivered through telehealth.
- It is important for the provider and the beneficiary to be in a quiet, private space that is free of distractions during the session.

Virtual delivery of services to the beneficiary will take place at the beneficiary's place of employment. A schedule for delivery of services, where the service will take place and ensure that the beneficiary has a private area to receive the service. The job coach will coordinate with the employer to ensure that the beneficiary has a place to receive services that is private and respectful of the beneficiary.

The beneficiary's need for hands on/ physical assistance on the job will already be established and therefore if the beneficiary requires hands on assistance, someone will be present to provide assistance to the beneficiary. If the need for virtual delivery of job coaching services arises, a process will be in place with the support worker and the job coach in order for the beneficiary to receive the assistance required on the job but that both services will not be billed at the same time.

The beneficiary will be integrated into the community through their place of employment and with the use of virtual ongoing job follow along services, the beneficiary can maintain the job when virtual assistance may be all that is allowed.

The job coach instructs the beneficiary on the process of operating the equipment needed to receive the virtual service. The job coach will establish the protocol with the employer/supervisor at the job if the beneficiary requires assistance with the use of the technology prior to the use of the virtual delivery of services and will ensure that the employer/supervisor/beneficiary knows the schedule for when the virtual delivery of services will occur. The provider will provide the beneficiary with written instructions for using the technology.

Transportation services (including wheelchair) are offered and billable as a component of Supported Employment services. Transportation may be provided to and/or from the participant's residence or a location agreed upon by the participant or authorized representative.

The beneficiary will be on the job and the already established protocol for his or her health and safety will be followed even if virtual delivery of the service is being provided. The virtual job coach will assist if necessary.

Requirements for virtual visits include:

- Must utilize some type of format that allows for face to face interaction
- Must be approved by LGE or OCDD State Office
- Utilize the Virtual Supported Employment Follow Along Services Report

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

The required minimum number of service hours per day per participant are as follows:
• Individual services - 1 hour (4 units); shall be based on needs based on the person centered plan and the ROW budget.
• Individual Services that assist a participant to develop and operate a micro-enterprise - 1 hour(4 units); shall be based on needs based on the person centered plan and the ROW budget.
• Group Employment services shall be billed in ¼ hour units up to eight hours per day and shall be based on needs based on the person centered plan and the ROW budget.
• Virtual SE follow along – billed in 15 minute increments shall be based on needs based on the person centered plan and the ROW budget.
Any time less than the minimum 15 minute unit of service for any model is not billable or payable.
Supportive Employment services cannot be billed for the same time as any other services.
One on One services shall be billed in quarterly hour units and shall be based on needs based on the person centered plan and the ROW budget.

Individual Supported Employment Services is delivered by an active Community Rehabilitation Program provider.
Group Employment services may be delivered either by an Adult Day Center who receives 15 hours of annual employment related training or a
Community Rehabilitation Program Provider.

When Supported Employment services are provided at a work site in which persons without disabilities are employees, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, but payment will not be made for the supervisory activities rendered as a normal part of the business setting.

Not available to individuals 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).

Provider is responsible for all transportation from the agency to all group employment work sites related to the provision of services.

Transportation is payable only when a supported employment service is provided on the same day.
Time spent in transportation to and from the program shall not be included in the total number of services hours provided per day.

Participant may receive more than one type of vocational/habilitation service per day as long as the billing criteria is followed and as long as the requirements for the minimum time spent on site are adhered to.

Billing for multiple vocational/habilitative services at the same time is prohibited

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	Community Rehabilitation Program (CRP) who are enrolled Medicaid providers of Supported Employment Services
Agency	Adult Day Center

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:

Community Rehabilitation Program (CRP) who are enrolled Medicaid providers of Supported Employment Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Employment Specialist must have a Completion Certificate of the approved Supported Employment initial 40 hour training program by an approved vendor and the 20 hours of employment training every two years

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

OCDD Provider Relations

Frequency of Verification:

Initially and every 2 years of employment continuing education hours

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:

Adult Day Center

Provider Qualifications

License *(specify):*

Providers must be licensed by the Louisiana Department of Health as a 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):*

Adult Day Care Site Supervisor must have a Completion Certificate of the approved Supported Employment initial 40 hour training program by an approved vendor and the 20 hours of employment training every two years.

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Department of Health Health Standards Section

Frequency of Verification:

Initially and every 2 years of employment continuing education hours

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:

Assistive Technology/Specialized Medical Equipment and Supplies

HCBS Taxonomy:

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

Service Definition *(Scope):*

Assistive Technology/Specialized Medical Equipment and Supplies service includes providing specialized devices, controls, or appliances which enable a participant to increase his/her ability to perform activities of daily living, ensure safety, and/or to perceive, control, and communicate within his/her environment. This service also includes medically necessary durable and non-durable equipment not available under the Medicaid State Plan and repairs to such items and equipment necessary to increase/maintain the independence and well being of the participant. All equipment, accessories and supplies must meet all applicable manufacture, design and installation requirements. The services under the Residential Options Waiver are limited to additional services not otherwise covered under the state plan.

This service includes:

Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;

Necessary medical supplies not available under the State Plan.

Repair of all items purchased,

The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;

Services consisting of purchasing, leasing or otherwise providing for the acquisition of assistive technology devices for participants;

Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

Coordination of necessary therapies, interventions, or services with assistive technology devices;

Training or technical assistance on the use for the participant, or, where appropriate, family members, guardians, advocates, authorized representatives of the participant, professionals, or others.

Medication Reminder System- an electronic device programmed to remind the individual to take medications by a ring, automated recording or other alarm. The electronic device may dispense controlled dosages of medication and may include a message back to the center if a medication has not been removed from the dispenser. Requires ability to self-administer medication with reminder.

Other equipment used to support someone remotely may include: electronic motion door sensor devices, door alarms, web-cams utilized in a HIPAA compliant manner that assure privacy, telephones with modifications (large buttons, flashing lights), devices affixed to wheelchair or walker to send alert when fall occurs, text-to-speech software, intercom systems, tablets with features to promote communication or smart device speakers.
Remote Technology Service Delivery: covers monthly response center/remote support monitoring fee and tech upkeep (no internet cost coverage.)
Remote Technology Consultation: the evaluation of tech support needs for an individual, including functional evaluation of technology available to address the person’s access needs and support person to achieve outcomes identified in the POC.

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

Must first access and exhaust items furnished under State Plan

Excludes items that are not of direct medical or remedial benefit to the participant

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: Assistive Technology/Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Assistive Devices

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled as a Medicaid HCBS provider.

Documentation on manufacturers letterhead that the agency listed on the Louisiana Medicaid Enrollment Form and Addendum (PE-50) is:

Authorized to sell and install

- o Assistive Technology,
- o Specialized Medical Equipment and Supplies, or
- o Devices for assistance with activities of daily living

and

Has training and experience with the application, use fitting and repair of the equipment or devices they propose to sell or repair

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Fiscal Intermediary

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:

Supports for Participant Direction

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

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Financial Management Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

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

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

The FEA provider is to perform the employer responsibilities of payroll processing which includes: issuance of paychecks; withholding federal, state and local tax and making tax payments to the appropriate tax authorities; issuance of W-2 forms; and meeting worker's compensation insurance requirements. The FEA provider is responsible for performing all fiscal accounting procedures including issuance of expenditure reports to the member, his/her representative, Louisiana Department of Health. The FEA provider must maintain a separate account for each participant while continually tracking and monthly reporting of funds, disbursements and the balance of the participant's service units. The FEA provider must have customer service available in order to assist participants and direct support workers with complaints/issues and to address questions regarding self-direction. The FEA provider must comply with all requirements included in the Fiscal Employer Agency Readiness Review and Performance Agreement.

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

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

This service is not duplicative with other waiver services.

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

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

Financial Management Services must be prior authorized.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Fiscal Employer Agent

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Fiscal Employer Agent

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid/MPSW

Frequency of Verification:

Initially, annually and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

specified in statute.

Service Title:

Community Life Engagement Development

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04070 community integration
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Life development should be utilized for the purpose of development of opportunities to assist individuals in becoming involved in their community and helping to develop a meaningful day for each individual. The purpose is to encourage and foster the development of meaningful relationships and memberships in the community, reflecting the person's choices and values. This service will be person-centered with an outcome of increased community activities and involvement in areas of interest as expressed by the individual. This should include church involvement, civic involvement, volunteering opportunities, as well as recreational activities. The activities should be integrated with the community and not segregated groups.

The role of the Community Life Engagement Developer (CLED) should be to develop individual activities, memberships and volunteer positions within the individual's community based off each individual's person centered plan and expressed interests and desires.

Transportation cost is included in the rate paid to the provider.

To utilize this service, the beneficiary may or may not be present.

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

This service can be billed at the same time the beneficiary is receiving a day or employment service.

15- Minute increments

240 units per POC year (60 hours) which includes the combination of shared and non-shared CLE.

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 Care

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Life Engagement Development

Provider Category:

Agency

Provider Type:

Adult Day Care

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 for licensed providers.

Frequency of Verification:

initially, annually or 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 Living Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Community Living Supports are provided to a participant in his/her own home and in the community to achieve and/or maintain the outcomes of increased independence, productivity, enhanced family functioning, provide relief of the caregiver, and inclusion in the community.
Community Living Supports focus on the achievement of one or more goals as indicated in the participant's approved Plan of Care by incorporating teaching and support strategies. Supports provided are related to the acquisition, improvement, and maintenance of independence, autonomy, and adaptive skills. This includes self-help, socialization, cognitive, and communication skills.

Community Living Supports may be shared by up to three participants who may or may not live together and who have a common direct service provider agency. Shared services must be agreed to by each participant and the health and welfare must be assured for each participant. If the person has a legal guardian, their approval must also be obtained. Each participant's Plan of Care must reflect shared services and include the shared rate for the service indicated.

The cost of transportation is built in to the Community Living Services rate and must be provided when integral to Community Living Services.

All Community Living Services participants are required to have an individualized back-up staffing plan and an individualized emergency evacuation plan which are to be submitted with their Plan of Care.

Family members who provide Community Living Supports must meet the same standards as unrelated provider agency staff.

Community Living Supports may be a self-directed service.

Community Living Support may share a DSW across two waivers Children's Choice (Family Support Services) and/or New Opportunities Waiver (Individual Family Supports) Recipients. However, sharing a DSW at the same time across all three waivers is not allowed.

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

Family members living in the home with the participant are allowed to be DSW staff, however hours will be capped at 40 hours per week per staff Sunday to Saturday.

An individual parent may provide care for their own child provided that the care is extraordinary from that of a child without a disability of the same age.
When a Legally Responsible Individual provides a paid service, this will be discussed in the person-centered planning meeting, including meeting established criteria for provision of extraordinary care vs. ordinary care, and included in the Comprehensive Plan of Care. The support coordinator or other designated party will ensure discussion held with the participant when LRI or other family member is not present on at least an annual basis to ensure this is the wishes of the participant; which will be documented per Guidelines for Support Planning. When a relative living in the home or a LRI provides a paid service, all support coordination visits will be conducted face-to-face, with no option for virtual visits. Payments to family members living in the home and LRIs will be audited on a semi-annual basis to ensure payment for services rendered.
The legally responsible individual must meet the provider qualifications (specified in Appendix C-3) that the state has established for the personal care or similar services for which payment may be made, and the state must conduct monitoring of such services as provided Appendix D-2, including the documentation and assurance that the services are delivered in accordance with the service plan. The state further defines extraordinary care in the waiver manual.

Providers may be allowed to render 40+ hours; however, the employer is required to comply with all DOL FLSA rules regarding employee payment. There is no rate adjustment to reimburse providers for overtime worked.

Community Living Supports staff are not allowed to sleep during billable hours of Community Living Supports.

Payment does not include room and board, maintenance, upkeep and improvement of the provider's or family's residence.
Community Living Supports may not be provided in a licensed respite care center. Payment will not be made for: Transportation to and from Supported Employment, Day Habilitation, or Prevocational Services, as transportation for these services are included in the rate for each vocational service.

May not be billed at the same time on the same day as:
Transportation-Community Access
Day Habilitation
Prevocational Services
Supported Employment
Respite Care Services-Out of Home
Adult Day Health Care or Monitored - In Home Care service

Community Living Supports are not available to participants receiving any of the following services:
Companion Care
Host Home
Shared Living

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Care Attendant

Provider Category	Provider Type Title
Individual	Direct Support Worker

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Supports

Provider Category:

Agency

Provider Type:

Personal Care Attendant

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Department of Health (LDH) (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: Community Living Supports

Provider Category:

Individual

Provider Type:

Direct Support Worker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The following individual qualifications are required for the direct care staff person for the Self-Direction Program:

Be at least 18 years of age;

Have a high school diploma, GED, or trade school diploma in the area of human services, or demonstrated competency, or verifiable work experience in providing support to persons with disabilities;

Must pass a criminal history background check;

Possess a valid social security number;

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal/employer agent

Frequency of Verification:

Initially, annually and as needed.

The fiscal agent is responsible to verify that direct support workers have met qualifications upon hire. The employer is responsible to ensure the direct service worker receives the training required to fulfill the services required in the plan of care.

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:

Companion Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Companion Care services provide personal care and supportive services to a participant who resides as a roommate with his/her caregiver. Companion Care services provide supports to assist the participant in achieving and/or maintaining increased independence, productivity, and community inclusion as identified in the participant's Plan of Care.

Companion Care providers assist the participant in locating an appropriate companion who will be compatible with the participant. The companion is an contracted employee of the provider agency and is paid as such by the provider. The provider assists in the development of an agreement between the participant and companion. The agreement defines all shared responsibilities between the participant and companion including a typical weekly schedule. This agreement becomes a part of the participant's Plan of Care. Revisions to this agreement must be facilitated by the provider and approved as part of the participant's Plan of Care following the same process as would any revision to a Plan of Care. Revisions can be initialized by the participant, the companion, the provider, or a member of the participants support team.

The provider will conduct an initial inspection of the participant's home with on-going periodic inspections with a frequency determined by the provider. The provider will contact the Companion at a minimum, once per week, or more often as specified in the participant's Plan of Care.

Responsibilities of the Companion include:

- Providing assistance with Activities of Daily Living (ADLs)
- Community integration
- Providing transportation
- Coordinating and assisting as needed with transportation to medical/therapy appointments
- Participating in and following the participants Plan of Care and any support plans
- Maintaining documentation /records in accordance with State and provider requirements
- Being available in accordance with a pre-arranged time schedule as outlined in the participants Plan of Care
- Purchasing own personal items and food.
- Being available 24 hours a day (by phone contact) to the participant to provide supports on short notice as a need arises

The provider is responsible for providing 24 hour oversight, back-up staff, and companion supervision. The provider must provide relief staff for scheduled and unscheduled absences, available for up to 360 hours (15 days) per Plan of Care year. The Companion Care provider's rate includes funding for relief staff for scheduled and unscheduled absences.

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

Companion Care services are not available to participants under the age of 18.

Payment will not be made for:
- Community Living Supports
- Shared Living
- Host Home
- Respite Care Services-Out of Home
- Transportation-Community Access
- Monitored in home caregiving (MIHC)

Payment does not include room and board or maintenance, upkeep and improvement of the participants or providers property.

Transportation to and from vocational programs are to be billed by the vocational provider as this is included in the specific vocational service rate.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Companion Care

Provider Category:

Agency

Provider Type:

Personal Care Attendant

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Department of Health (LDH) (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:

Dental Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11070 dental services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Dental services are accessed through one of the state's contracted PAHPs/Dental Plans (reference LA.0005). Dental services include:
•Diagnostic services;
•Preventive services;
•Restorative services;
•Endodontics;
•Periodontics;
•Prosthodontics;
•Oral and maxillofacial surgery;
•Orthodontics; and
•Emergency care;
•Adjunctive General Services.

NON-COVERED SERVICES
Non-covered services include but are not limited to the following :
- Services that are not medically necessary to the member's dental health
- Dental care for cosmetic reasons
- Experimental procedures
- Plaque control
- Certain types of x-rays
- Routine post-operative services - these services are covered as part of the fee for initial treatment provided
- Treatment of incipient or non-carious lesions (other than covered sealants and fluoride)• Services that are eligible for reimbursement by insurance or covered under any other insurance or medical health plan
- Dental expenses related to any dental services:
  - Started after the member's coverage ended
  - Received before the member became eligible for these services
- Administration of in-office pre-medication

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

Dental services in this waiver are not available to children(up to 21 years of age) since they have access through EPSDT.
•Periodic oral examination-Pt of Record:Limited 1 per 6mth period
•Comprehensive oral exam-New Pt:Reimbursed 1 in 3yr period performed by same/other Medicaid general dentist located in same office as billing provider
•Intraoral-Complete series of radiographic images:Reimbursed 1 per 12mth period except when performed by Medicaid-recognized dental specialist
•Intraoral-Periapical 1st radiographic image & Intraoral-Periapical each additional radiographic image:When taken in addition to bitewing radiographic images(D0272)- limited to total of 5 & payable when purpose is to obtain info in regard to specific pathological condition other than caries
•Bitewings-2 Radiographic images:Limited to 1 set per yr when performed by same billing provider, except when performed by Medicaid-recognized dental specialist
•Panoramic radiographic image:Only 1 per day by any provider/facility/group & limited to 1 service every 12mths by same provider
•Oral/facial images:Limited to 2 units per same date of service
•Prophylaxis-Adult:Limited to 1 per 6mth period.More frequent may be approved if medically necessary
•Topical application/fluoride-excluding varnish:Reimbursed 1 per 6mth period
•Interim caries arresting medicament application-per tooth:Reimbursed per tooth every 180 days
•Amalgam-1 surface only posterior-permanent teeth;Amalgam-2 surfaces posterior-permanent teeth only;Amalgam-3 surfaces posterior-permanent teeth only;Amalgam-4 surfaces posterior-permanent teeth only:Duplicate surfaces not reimbursed on same tooth, in amalgam restorations,in a 12mth period by any provider
•Pin retention,per tooth,in addition to restoration:Limited to 1 per tooth in 12mth period
•Therapeutic pulpotomy(excluding final restoration):Limited to 1 every 24mth period, per tooth
•Endodontic Therapy,molar(excluding final restoration):3rd molar root canals are not reimbursed
•Retreatment of previous root canal therapy,anterior:Not payable to same dentist/dental group who performed initial root canal.Beneficiaries may seek service from a different dentist/dental group
•Apexification/recalcification,Interim Medication Replacement:Limited to max of 3 tx per tooth
•Periodontal scaling & root planing,4 or more teeth per quadrant:Allowed 1 in 12mth period.Only 2 units of periodontal scaling & root planing may be reimbursed per day.For beneficiaries requiring hospitalization for dental treatment,a max of 4 units per day is allowed
•Full mouth debridement to enable comprehensive eval & dx:1 in 12mth period.Not allowed in 12mths of D1110 or D1120
•Complete denture, maxillary;Complete denture,mandibular;Immediatedenture,maxillary;Immediate denture,mandibular;Maxillary partial denture,resin base(including retentive/clasping materials,rests & teeth);Mandibular partial denture,resin base(including retentive/clasping materials,rests & teeth):1 per beneficiary per arch allowed in 8yr period, permanent teeth only
•Repair broken complete denture base,mandibular;Repair broken complete denture base,maxillary;Replace missing or broken tooth,complete denture/per tooth;Repair resin denture base,partial denture,mandibular;Repair resin partial denture base,maxillary;Repair/replace broken retentive/clasping materials,partial denture-per tooth;Replace missing/broken teeth,partial denture,per tooth;Add tooth to existing partial denture;Add clasp to existing partial denture-per tooth:Allowed only if more than 1 yr elapsed since denture insertion
•Reline complete maxillary denture(indirect);Reline complete mandibular denture(indirect);Reline maxillary partial denture(indirect);Reline mandibular partial denture(indirect):Allowed only if more than 1 yr elapsed since denture insertion.A combination of 2 complete or partial denture relines or 1 complete or partial denture & 1 reline in the same arch are allowed in a 8yr period
•Pontic-porcelain fused to predominantly base metal:Limited to 1 in a 8yr period
•Retainer-cast metal for resin bonded fixed prosthesis:Limited to 2 per beneficiary in a 8yr period
•Placement of device to facilitate eruption of impacted tooth;Transseptal fiberotomy/supra crestal fiberotomy,by report:Only reimbursable in conjunction with a Medicaid covered comprehensive orthodontic tx plan
•Alveoloplasty in conjunction with extractions-per quadrant:A min of 3 adj teeth must be extracted
•Incision & drainage of abscess-intraoral soft tissue:Not reimbursed for primary teeth
•Palliative(emergency) tx of dental pain:A max of 2 palliative tx per beneficiary are available annually
•Inhalation of nitrous oxide/analgesia,anxiolysis:Only reimbursed when restorative &/or surgical services(codes D2140-D4999 & D7140-D7999) are performed.Not reimbursable when billed in conjunction with D9248
•IV mod conscious sedation/analgesia-1st 15 min:Only allowable in conjunction with difficult impactions or other extensive surgical procedures done in office setting
•IV mod conscious sedation/analgesia-each additional 15 min increment:Max of 3 units of D9243 available per beneficiary per visit

•Non-IV conscious sedation:Max of 4 non-IV conscious sedation/analgesia administrations,per beneficiary available annually by same billing provider or other Medicaid provider located in same office as billing provider.Not reimbursed on the same day,by any provider as proc codes D9230(Nitrous Oxide)& D9997(Dental CM)
•Hospital call:Only reimbursed for dates of service on which restorative &/or surgical services (codes D2140-D4999 & D7140-D7999) are performed. Limited to 1 per 6mth period,per beneficiary
•D9997 Dental CM-patients with special health care needs:A max of 4 services,per beneficiary available annually by same billing provider or other Medicaid provider located in same office as billing provider.Additional services may be approved if medically necessary

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	Dentist-Individual or Group

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dental Services

Provider Category:

Agency

Provider Type:

Dentist-Individual or Group

Provider Qualifications

License *(specify):*

Revised Statute Title 46 Professional and Occupational Standards; Part XXXIII-Dental Health Professionals

Revised Statute Title 37
Professions and Occupations, Chapter 9-Dentists
Dental Practice Act

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

PAHP

Frequency of Verification:

Initially and every 3 years

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:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Environmental Accessibility Adaptations include physical adaptations to the participant's home or vehicle which are necessary to ensure health, welfare and safety to the participant, or which enable the participant to function with greater independence, without which the participant would require additional supports or institutionalization. Environmental Adaptations must be specified in the participant's Plan of Care.

Home Adaptations:

Home adaptations pertain to modifications that are made to a participant's primary residence. Such adaptations to the home may include bathroom modifications, ramps, other adaptations to make the home accessible to the participant. The service must be for a specific approved adaptation.

May be used only to cover the difference between constructing the adaptive component and building an accessible or modified component. The service must be for a specific approved adaptation.
May be applied to rental or leased property only with the written approval of the landlord and approval of LGE;
May include the performance of necessary assessments to determine the type(s) of modification(s) that are necessary;
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 participant;

Vehicle Adaptations:

Vehicle adaptations pertain to modifications that are made to a vehicle which is the participant's primary means of transportation. 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. Vehicle adaptations may include the performance of necessary assessments to determine the type(s) of necessary modifications. The service must be for a specific approved adaptation.

Adaptations to home and vehicle include the following:
Training the participant and provider in the use and maintenance of the Environmental Adaptation(s);
Repair of equipment and or devices, including battery purchases for vehicle lifts and other reoccurring replacement items that contribute to the ongoing maintenance of the approved adaptation(s) and
Standard manufacturer provided service contracts and warranties.
Modifications may be applied to rental or leased property with the written approval of the landlord and approval of the LGE.

All Environmental Accessibility Adaptations to home and vehicle must meet all applicable standards of manufacture, design and installation.

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

Home adaptation exclusions:

Not intended to cover basic construction cost. May not include modifications which add to the total square footage of the home except when the additional square footage is necessary to make the required adaptations function appropriately. (For example, if a bathroom is very small and a modification cannot be done without increasing the total square footage, this would be considered as an approvable cost). When new construction or remodeling is a component of the service, payment for the service is to only cover the difference between the cost of typical construction and the cost of specialized construction.

May not include modifications to the home which are of general utility and not of direct medical or remedial benefit to the participant (i.e., flooring, roof repair, central air conditioning, hot tubs, swimming pools, exterior fencing, general home repair, maintenance, etc).

May not be furnished to adapt living arrangements that are owned or leased by paid caregivers or providers of waiver services; and

Service warranties and contracts above those provided by the manufacturer at the time of purchase (e.g. extended warranties, extended service contracts)

Vehicle adaptation exclusions:

Modifications which are of general utility and are not of direct medical or remedial benefit to the participant;

Purchase or lease of a vehicle;

Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications;

Car seats; and

Service warranties and contracts above those provided by the manufacturer at the time of purchase (e.g. extended warranties, extended service contracts)

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 Modification Agency

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 Modification Agency

Provider Qualifications

License *(specify):*

Home Adaptations:
Current license from the State Licensing Board of Contractors for any of the following building trade classifications:

- General Contractor
- Home Improvement
- Residential Building

Or
If a current Louisiana Medicaid provider of Durable Medical Equipment, documentation from the manufacturing company (on their letterhead) that confirms the provider is an authorized distributor of a specific product that attaches to a building. Letter must specify the product and state that the provider has been trained on its installation.

Vehicle Adaptations:
Current License as a Specialty Vehicle Dealer with accreditation for Structural Vehicle Modifier in state of licensure.

All Environmental Adaptations providers must comply with all applicable Local (City or Parish) Occupational License(s).

Certificate *(specify):*

Other Standard *(specify):*

All Environmental Adaptation providers must meet any state or local requirements for licensure or certification, as well as the person performing the service (i.e., building contractors, plumbers, electricians, engineers, etc.). When state and local building or housing code standards are applicable, modifications to the home shall meet such standards and all services shall be provided in accordance with applicable State or local requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency though Medical Fiscal Intermediary

Frequency of Verification:

Initially 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:

Host Home

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Host Home services are personal care and supportive services provided to a participant who lives in a private home with a family who is not the participant's parent, legal representative, or spouse. Host Home Families are a stand-alone family living arrangement in which the principle caregiver in the Host Home assumes the direct responsibility for the participant's physical, social, and emotional well-being and growth in a family environment. Host Home services are to take into account compatibility with the Host Home Family members including age, support needs, privacy needs.

If the participant is a child, the Host Home Family is to provide the supports required to meet the needs of a child as any family would for a minor child. Support needs are based on the childs age, capabilities, health, and special needs. A Host Home Family can provide compensated supports for up to two participants, regardless of the funding source.

Host Home services include assistance with personal care, leisure activities, social development, family inclusion, and community inclusion. Natural supports are also encouraged and supported when possible. Supports are to be consistent with the participant's skill level, goals, and interests.

Host Home Provider:
Ensure availability, quality and continuity of Host Home services
Arrange, train, and oversee Host Home services (Host Home Family)
Have 24 hour responsibility which includes back-up staffing for scheduled and unscheduled absences of the Host Home Family for up to 360 hours (15 days) as authorized by the participant's Plan of Care.
Relief staffing may be provided in the participant's home or in another Host Home Family's home.

Host Home Family:
Must attend participant's Plan of Care meeting and participate including providing information needed in the development of the plan
Must follow all aspects of the participant's Plan of Care and any support plans
Must assist the participant in attending appointments (i.e., medical, therapy, etc.)
Must provide transportation as would a natural family member
Must maintain participant's documentation
Must follow all requirements for staff as in any other waiver service

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

Children eligible for Title IV-E services are not eligible for Host Home services.

Payment will not be made for services provided by a relative who is a:
Parent(s) of a minor child;
Legal guardian of an adult or child with developmental disabilities;
Parent(s) for an adult child regardless of whether or not the adult child has been interdicted;
or Spouse

Payment will not be made for services provided by a relative who is a:

Payment does not include room and board or maintenance, upkeep and improvement of the Host Home Familys residence. Environmental Adaptations are not available to participants receiving Host Home services since the participants place of residence is owned or leased by the Host Home Family.

Payment will not be made for:
Community Living Supports
Companion Care
Shared Living
Respite Care Services-Out of Home
Transportation-Community Access
One-Time Transition Services or Monitored in Home Care giving (MIHC)

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	Substitute Family Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Host Home

Provider Category:

Agency

Provider Type:

Substitute Family Agency

Provider Qualifications

License *(specify):*

Children:
Child Placing Agency License
LAC Title 67 Chapter 73

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

Certificate *(specify):*

Other Standard *(specify):*

Host Home Service provider agencies must meet the following qualifications:
Have experience in delivering therapeutic services to persons with developmental disabilities;
Have staff who have experience working with persons with developmental disabilities; and
Screen, train, oversee and provide technical assistance to the Host Home Family in accordance with OCDD requirements including the coordination of an array of medical, behavioral and other professional services geared to persons with DD; and
Must provide on-going assistance to the Host Home Family so that all HCBS waiver health and safety assurances, monitoring and critical incident reporting requirements are met.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Family and Child Services (Bureau of Licensing)

Louisiana Department of Health (LDH) (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:

Housing Stabilization Service

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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 Louisiana Department of Health and Statewide Management Organization for Behavioral Health Services plus either:

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

Verification of Provider Qualifications

Entity Responsible for Verification:

OAAS, the program office housing the PSH Director

Frequency of Verification:

Initial and annual thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

specified in statute.

Service Title:

Housing Stabilization Transition Service

HCBS Taxonomy:

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

Service Definition *(Scope):*

Housing Stabilization Transition Service enables participants who are transitioning into a PSH unit, including those transitioning from institutions, to secure their own housing. The service is provided while the participant is in an institution and preparing to exit the institution using the waiver. The service includes the following components:

1. Conduct a housing assessment identifying the participant's preferences related to housing (type, location, living alone or with someone else, accommodations needed, other important preferences) and needs for support to maintain housing (including access to, meeting terms of lease, and eviction prevention), budgeting for housing/living expenses, obtaining/accessing sources of income necessary for rent, home management, establishing credit and understanding and meeting obligations of tenancy as defined in lease terms.
2. Assist participant to view and secure housing as needed. This may include arranging or providing transportation. Assist participant to secure supporting documents/records, completing/submitting applications, securing deposits, locate furnishings.
3. Develop an individualized housing stabilization service provider plan based upon the housing assessment that includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies where other provider(s) or services may be required to meet the goal.
4. Participate in the development of the plan of care, incorporating elements of the housing stabilization service provider plan.
5. Look for alternatives to housing if permanent supportive housing is unavailable to support completion of transition.

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

Available only to participants who:

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

Limited to:

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

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

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

☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Permanent Supportive Housing Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Permanent Supportive Housing Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Community Psychiatric and Support Team

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

OAAS, the program office housing the PSH Director

Frequency of Verification:

Initial and annual thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Nursing

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

Nursing services must be included in the participant's Plan of Care and have the following:
- Physician's order,
- Physician's letter of medical necessity,
- 90-L,
- Form 485,
- Individual nursing service plan,
- Summary of medical history, and
- Skilled nursing checklist.

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

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home Health Agency License
LA RS Title 40:2016-2016.40

Certificate *(specify):*

Other Standard *(specify):*

Nurses must have 1 year experience serving persons with developmental disabilities. Experience may include any of the following:

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

Paid, full-time nursing experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);

Paid, full-time nursing experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or

Paid, full-time nursing experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

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

The following activities do not qualify for the required experience:

Volunteer nursing experience; or

Experience gained by caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Department of Health (LDH) (Health Standards Section

Frequency of Verification:

Initially, annually and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing

Provider Category:

Agency

Provider Type:

Shared Living

Provider Qualifications

License *(specify):*

Providers must be licensed by the Louisiana Department of Health as a home and community-based services provider and meet the module requirements for Supervised Independent Living-Conversion. LAC 48:1.Chapter 50

Certificate *(specify):*

Other Standard *(specify):*

Nurses must have 1 year experience serving persons with developmental disabilities. Experience may include any of the following:

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

Paid, full-time nursing experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);

Paid, full-time nursing experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or

Paid, full-time nursing experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

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

The following activities do not qualify for the required experience:

Volunteer nursing experience; or

Experience gained by caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Department of Health (LDH) (Health Standards Section

Frequency of Verification:

Initially, annually and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

One-Time Transitional Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

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

Service Definition *(Scope):*

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

One Time Transitional Services are non-reoccurring set-up expenses to assist a participant who is moving from an institutional setting to their own home.

One-Time Transitional Services may be accessed for the following:
- Non-refundable security deposit;
- Utility deposits;
- Bedroom furniture;
- Living room furniture;
- Table and chairs;
- Window blinds;
- Kitchen items (i.e., food preparation items, eating utensils, etc);
- Moving expenses; and
- Health and safety assurances (i.e., pest eradication, one-time cleaning prior to occupancy, etc.).

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

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

There is a one-time,life time maximum service of $3,000 per participant. Service expenditures will be prior authorized and tracked by the prior authorization contractor.

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

Security deposits are not to include rental payments.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transition Support Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: One-Time Transitional Services

Provider Category:

Agency

Provider Type:

Transition Support Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

BHSF (Medicaid) Provider Enrollment Agreement

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Department of Health (LDH) (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:

Personal Emergency Response System

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

Installation, participant training, a monthly monitoring fee, and the cost of maintenance are included in the Personal Emergency Response System service. Cell phone service is not included and is not a covered waiver service. In additional to the current system that plugs into a landline, a system that uses cellular service may be used and the landline is not required; this system will have a fall detection pendant.

Enhance Services- Mobile Emergency Response System (MERS) an on-the go mobile medical alert system, used in and outside the home.
This system will have cellular/GPS technology, two-way speakers and no base station will be required.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Emergency Response System

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Personal Emergency Response System

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must comply with all applicable federal, state, county (parish) and local laws and regulations and meet manufacturers specifications, response requirements, maintenance records, and enrollee education. The providers Response Center shall be staffed by trained professionals.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Fiscal Intermediary

Frequency of Verification:

Initially, annually and as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Professional Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

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

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

Professional Services can include:

Assistance in increasing independence, participation and productivity in the participant's home, work and/or community environments

Assessments and/or re-assessments specific to the area of specialty with the goal of identifying status and developing recommendations, treatment, and follow-up

Providing information to the participant, family, caregivers, along with other support team members to assist in planning, developing, and implementing a participant's Plan of Care

Providing consultative services and recommendations as the need arises

Providing training to the participant, family, and caregivers with the goal of increased skill acquisition and proficiency.

Providing therapy to the participant necessary to the development of critical skills

Intervening in a crisis situation with the goal of stabilizing and addressing issues related to the cause(s) of the crisis; activities may include development of support plan(s), training, documentation strategies, counseling, on-call supports; back-up crisis supports, on-going monitoring and intervention

Providing training and counseling services for natural supports and caregivers in a home setting with the goal of developing and maintaining healthy, stable relationships.

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

Private Insurance must be billed and exhausted prior to accessing waiver funds.

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:

Agency

Provider Type:

Rehabilitation Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Medicare Certification Letter confirming enrollment as either a Rehabilitation Agency or a Comprehensive Outpatient Rehabilitation Facility (CORF)

Other Standard *(specify):*

Agency staff providing professional services to ROW participants must:

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

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

Paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);

Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or

Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

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

The following activities do not qualify for the required experience:

Volunteer professional experience; or

Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Department of Health (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:

Registered Dietician

Provider Qualifications

License *(specify):*

Dietician/Nutritionist License
LA RS 37:3086

Certificate *(specify):*

Other Standard *(specify):*

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

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

Paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);

Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or

Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

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

The following activities do not qualify for the required experience:

Volunteer professional experience; or

Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Board of Examiners in Dietetics and Nutrition

Frequency of Verification:

Initially, annually and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:

Agency

Provider Type:

Federally Qualified Health Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

HRSA Grant Award letter
or
CLIA Certificate (if applicable)

Other Standard *(specify):*

Agency staff providing professional services to ROW participants must:

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

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

Paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);

Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or

Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

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

The following activities do not qualify for the required experience:

Volunteer professional experience; or

Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Department of Health (LDH) (Health Standards Section

Frequency of Verification:

Initally, annually, and as necessary.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:

Agency

Provider Type:

Substitute Family Care

Provider Qualifications

License *(specify):*

Children:
Child Placing Agency
LAC Title 67 Chapter 73

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

Certificate *(specify):*

Other Standard *(specify):*

Agency staff providing professional services to ROW participants must:

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

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

Paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);

Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or

Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

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

The following activities do not qualify for the required experience:

Volunteer professional experience; or

Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Family and Child Services (Bureau of Licensing)

Louisiana Department of Health (LDH) (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:

Speech Therapist

Provider Qualifications

License *(specify):*

Speech Therapist License
LA RS 37:2650-2666

Certificate *(specify):*

Other Standard *(specify):*

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

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

Paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);

Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or

Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

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

The following activities do not qualify for the required experience:

Volunteer professional experience; or

Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Board of Examiners for Speech Language Pathology and Audiology

Frequency of Verification:

Initially, annually, and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

Physical Therapist License
LA RS 37:2401-2421

Certificate *(specify):*

Other Standard *(specify):*

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

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

Paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);

Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or

Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

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

The following activities do not qualify for the required experience:

Volunteer professional experience; or

Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Physical Therapy Board

Frequency of Verification:

Initially, annually and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:

Agency

Provider Type:

Shared Living

Provider Qualifications

License *(specify):*

Providers must be licensed by the Louisiana Department of Health as a home and community-based services provider and meet the module requirements for Supervised Independent Living and/or Supervised Independent Living-Conversion.
LAC 48:1.Chapter 50

Certificate *(specify):*

Other Standard *(specify):*

Agency staff providing professional services to ROW participants must:

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

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

Paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);

Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or

Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

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

The following activities do not qualify for the required experience:

Volunteer professional experience; or

Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Department of Health (LDH) (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):*

Psychology License
LA RS 37:2356

Certificate *(specify):*

Other Standard *(specify):*

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

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

Paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);

Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or

Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

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

The following activities do not qualify for the required experience:

Volunteer professional experience; or

Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana State Board of Examiners of Psychologists

Frequency of Verification:

Initially, every two years, and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home Health Agency License
LA RS 40.2116.31-2116.40

Certificate *(specify):*

Other Standard *(specify):*

Agency staff providing professional services to ROW participants must:

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

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

Paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);

Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or

Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

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

The following activities do not qualify for the required experience:

Volunteer professional experience; or

Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Department of Health (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:

Occupational Therapist

Provider Qualifications

License *(specify):*

Occupational Therapist License
LA RS 37:3001-3014

Certificate *(specify):*

Other Standard *(specify):*

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

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

Paid, full-time professional experience in specialized service/treatment settings for persons with developmental disability (i.e., intermediate care facilities for persons with a developmental disability);

Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or

Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

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

The following activities do not qualify for the required experience:

Volunteer professional experience; or

Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana State Board of Medical Examiners

Frequency of Verification:

Initially, annually, or as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:

Individual

Provider Type:

Social Worker

Provider Qualifications

License *(specify):*

Social Work License
LA RS 37:2701-2723

Certificate *(specify):*

Other Standard *(specify):*

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

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

Paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);

Paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or

Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

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

The following activities do not qualify for the required experience:

Volunteer professional experience; or

Experienced gained in caring for a relative or friend with a developmental disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana State Board of Social Work Examiners

Frequency of Verification:

Initially, annually and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transportation-Community Access

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

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

Service Definition *(Scope):*

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

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

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

Prior to accessing Transportation-Community Access service, the participant is to utilize free transportation provided by family, friends, and community agencies. When appropriate, the participant should access public transportation or the most cost-effective method of transportation prior to accessing Transportation-Community Access service.

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

Limited to no more than three round-trips per day.

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

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

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

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

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

☒ **Provider managed**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

NEMT (Friends and Family Transportation)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Maintain compliance with:
State minimum automobile liability insurance coverage,
Possess a current state inspection sticker, and
Possess a current valid driver's license.
May provide transport for up to three identified participants

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Department of Health (Bureau of Health Services Financing)

Frequency of Verification:

Initially for enrollment of providers

Appendix C: Participant Services

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

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

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

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

Appendix C: Participant Services

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

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

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

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

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

The Louisiana State Police (LSP), or the LSP designee companies they recognize as competent, perform the actual criminal history/background checks and security check on the individual.

New employee background checks/security checks are reviewed by Health Standards Section during licensing and monitoring reviews.

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

Childrens Code Title VI, Chapter 1, Article 601-606 and Title VI, Chapter 5, Article 609-611;

LA. R.S. 14:403, abuse of children;

LA R.S. 14:403.2 XI-B; abuse and neglect of adults (includes disabled adults); and

LA R.S. 40:1300.53, Criminal History Checks on Non-licensed Persons and Licensed Ambulance Personnel The LA R.S. 40:1300.52 statute were redesignated by HCR 84 Act 816 of the 2015 Regular Legislative Session as LA R.S. 40-1203.3 and LA R.S. 40-1203.2 respectively. These statutes require the criminal background check to include a security check. The security check will search the national sex offender public registry. All direct support provider agencies are encouraged to become familiar with, and have on hand, the above mentioned statutes as a reference when hiring.

ACT 816 finalized in 6/30/2006 added security checks for identification of sex offenders & authorized release of potential employees results to the employer.

ACT 35 finalized in 6/15/2009 prohibited providers hiring any staff with a conviction for a list of 17 crimes (non-waivable offenses).

Home & Community-Based Services Providers Minimum Licensing Standards (LAC 48: I Chapter 50) December 20, 2017. This HCBS Licensing rule includes:

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

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

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

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

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

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

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

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

The Louisiana Department of Health (LDH), Health Standards Section has a contractor who maintains the Direct Service Worker Abuse Registry for the state. Health Standards has a RN Program Manager who administers the Direct Service Worker Abuse Registry Program with oversight of the contractor.

Each licensed provider is required to conduct the screening against the registry to assure a finding is not placed prior to employment and every six months thereafter to assure a finding is not placed in accordance with the Direct Service Worker Registry Final Rule published on May 20, 2019 Louisiana Registry.

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

Appendix C: Participant Services

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

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law 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.*

The state ensures that the provision of services by a legally responsible individual is in the best interest of the participant using the team approach and must be on the plan of care. Any ROW service may be provided by a member of the participant's family provided that the family member passes all background checks. Family members and individuals that live in the home with the recipient cannot exceed a total of 40 hours per week per staff. Family members that may provide services include parents of an adult child, siblings, grandparents, aunts, uncles, cousins and in-laws. The family member must become an employee of the participant's agency of choice or under self-direction 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. The state ensures that the provision of services by a legally responsible individual is in the best interest of the participant using the team approach and must be on the plan of care. The Legally responsible relative who is the employer cannot be the employee. When a Legally Responsible Individual(LRI) provides a paid service, this will be discussed in the person-centered planning meeting, including meeting established criteria for the provision of extraordinary care vs. ordinary care, and included in the Comprehensive Plan of Care. The Support Coordinator or other designated party will ensure discussion held with the participant when LRI or other family member is not present on at least an annual basis to ensure this is the wishes of the participant; which will be documented per Guidelines for Support Planning. When a relative living in the home or a LRI provides a paid service, all support coordination visits will be conducted face-to-face, with no option for virtual visits. Payments to family members living in the home and LRIs will be audited on a semi-annual basis to ensure payment for services rendered.

☒ **Self-directed**

☒ **Agency-operated**

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.

ROW CLS service may be provided by a member of the participant's family. 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. The state ensures that the provision of services by a legally responsible individual is in the best interest of the participant using the team approach and must be on the plan of care. Any ROW service may be provided by a member of the participant's family provided that the family member passes all background checks. Family members and individuals that live in the home with the recipient cannot exceed a total of 40 hours per week per staff. Family members that may provide services include parents of an adult child, siblings, grandparents, aunts, uncles, cousins and in-laws. 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. The state ensures that the provision of services by a legally responsible individual is in the best interest of the participant using the team approach and must be on the plan of care. Any ROW service may be provided by a member of the participant's family provided that the family member passes all background checks. Family members and individuals that live in the home with the recipient cannot exceed a total of 40 hours per week per staff. Family members that may provide services include parents of an adult child, siblings, grandparents, aunts, uncles, cousins and in-laws. 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. When a Legally Responsible Individual(LRI) provides a paid service, this will be discussed in the person-centered planning meeting, including meeting established criteria for the provision of extraordinary care vs. ordinary care, and included in the Comprehensive Plan of Care. The Support Coordinator or other designated party will ensure discussion held with the participant when LRI or other family member is not present on at least an annual basis to ensure this is the wishes of the participant; which will be documented in the POC. When a relative living in the home or a LRI provides a paid service, all support coordination visits will be conducted face-to-face, with no option for virtual visits. Payments to family members living in the home and LRIs will be audited on a semi-annual basis to ensure payment for services rendered.

○ **Other policy.**

Specify:

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

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

Via the Louisiana Medicaid website;

Through state facilitated stakeholder meetings regarding waiver services; and

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

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

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

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

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

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

BHSF, or its designee assigns each new enrolled provider a unique Medicaid provider number and sends the OCDD 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 BHSF 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

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

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

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

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
C.a.i.a.1. Number and percentage of new HCBS providers who meet HCBS licensing standards prior to furnishing waiver services. Percentage = number of HCBS providers who meet HCBS licensing standards prior to furnishing waiver services/Total number of initial 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	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	*(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**

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

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

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**

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

Performance Measure:
C.a.i.b.2 Number and percentage of direct service workers (for self-direction participants) screened by the fiscal agent who were eligible for hire due to passing a criminal background check. Percentage = Number of newly hired self-direction employees who passed 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**
	☐ **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. Number and percentage of HCBS licensed providers meeting annual provider training requirements in accordance with state laws/policies. Numerator = number of HCBS licensed providers meeting annual provider training requirements in accordance with state laws/policies; Denominator = / Total number of licensed HCBS providers.

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

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

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 there is a finding of abuse, neglect or misappropriation. An individual with a finding of abuse, neglect or misappropriation on the registry may not be hired.
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. Providers who fail to attain substantial compliance following the issuance of a provisional license may be denied license renewal or may have the license revoked.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 ROW, the general remediation procedure the State utilizes is 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 of the license or license revocation which will result in 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.

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	☒ **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.

The Inventory for Client and Agency Planning (ICAP) is a standardized assessment instrument that is designed to assess the status, adaptive functioning, and service needs of an individual. The ICAP is applicable to participants of all ages (infant to adult). Information is obtained from the participant's family, advocate, and/or direct care staff. The ROW budget is based on the ICAP acuity score. If participants have increased needs, additional services may be accessed based on assessed needs by moving into a higher acuity level with increased budget amounts. All services are subject to a limit based on the ICAP acuity score.

The ICAP score for a participant is used to determine the participant's level of support needs which is then used to determine the participant's individual budget level. If a participant's level of support needs change, the ICAP is readministered to determine the participant's budget change.

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

Intermittent: supports on an as needed basis. Characterized as episodic in nature, the person does not always need the support(s), or short-term supports needing during life-span transition.

Limited: supports characterized by consistency over time, time-limited but not of an intermittent nature.

Extensive: supports characterized by regular involvement (e.g., daily) in at least some environments and not time-limited.

Pervasive: supports characterized by their constancy, high intensity, provision across environments, and potential life-sustaining nature.

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

Geographic factors do not affect the budget amount.

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting

requirements, at the time of this submission and ongoing.

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

The timelines and plans for the settings assessment has been added to Attachment #2.

•Waiver beneficiaries will reside in the home of their choosing in the community which could include living with family, a roommate of their choice or living alone. If renting, an individual will have a lease in place that doesn't infringe upon their rights.
•An individual may choose to reside in a provider owned residential setting. If renting, an individual will have a lease in place that doesn't infringe upon their rights.
Waiver beneficiaries will have a choice to receive services in the following:
•In the community alongside people who do not receive Medicaid including typical community settings, including businesses and other places/activities that are offered in the community.
•Prior to being added to the Freedom of Choice list, a provider of CLE services will receive training in the HCBS Settings Rule criteria that must be followed. If the provider meets all of the criteria, the provider is added to the Freedom of Choice list.
•For CLE providers, an annual onsite visit that includes review of records and interviews with individuals and staff will be completed by the Local Governing Entity or OCDD State Office to ensure that the HCBS Settings Rule criteria continues to be met. If the provider is found to be out of compliance at any point, the LGE/OCDD will work with the provider to come back into compliance with an established time line and will provide technical assistance and guidance.
•An annual survey will be conducted with each individual who receives waiver services to ensure they are receiving the services of their choosing.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Plan of Care

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

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

The initial planning meetings are conducted in a face-to-face visit in the participant's place of residence During the initial visit, the participant chooses who will be part of his/her planning process. The Support Coordinator assists the participant/family in contacting the team members with the date(s) and time(s) of meeting(s). The Support Coordinator facilitates the planning meeting with the participant/family driving the planning process. Virtual meetings may occur for quarterly meetings if established criteria are met. All annual and one other meeting per year must be held face-to-face.

Virtual visits are allowed if the following conditions are met:

1. The beneficiary/family is in agreement that a virtual visit is in the best interest of the beneficiary, and
2. The SC is in agreement, and
3. The provider agencies are in agreement, and
4. The legally responsible individual or family members living in the home are not paid caregivers, and
5. There are no instances in the past two years, and

a. Discovery by SC or reported by provider of an accident, incident, injury that meets Critical Incident Review Criteria
b. Lack of desired personal outcomes: such as education, employment, and community engagement
c. Unsafe living conditions, lack of sanitation, lack of food and supplies
d. Change in involvement of natural supports
e. Medication issues
f. Changes in behavior, medical status or appearance (weight gain/loss)

6. Technology is available to complete the visit with direct observation of the beneficiary and the home, and
7. There is evidence that the requirements for the quarterly visit can be completed virtually.

The SC will obtain an electronic signatures/or electronic verification via secure email consent from service providers and the individual or representative, in accordance with the state’s HIPAA requirements at end of Virtual visit.

The employer should act in the best interest of the beneficiary hiring staff to meet his/her needs providing safeguard against exploitation of the beneficiary.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

A. PLAN OF CARE (POC) DEVELOPMENT AND TIMING

Linkage to support coordination through certification for waiver services may take up to 90 days. During the 90 day period, the following activities occur:

•Initial support coordinator (SC) contact with the participant
•The support coordinator contacts the family to arrange a face-to-face meeting at a location convenient to the family.
•The support coordinator will schedule a time with the participant and family to assess the participant's needs utilizing a needs based assessment.

The POC plan is developed through a person centered process that includes the participant and whomever the participant chooses which could include family, supporters, advocates, employment or habilitation providers, and whomever makes up the support team for the participant. During the planning process and planning discussions, it may be determined that there are unmet needs present which neither the current assigned waiver nor other available non-waiver supports or services are able to meet. In these circumstances, it may be appropriate for the participant, with assistance from the support team, to request a move up to the next tier waiver via OCDD's Tiered Waiver Process, if the services available in that waiver can appropriately meet those needs .

A request to move to second Tiered Waiver Process -the Residential Options Waiver. The Inventory for Client and Agency Planning (ICAP) is completed. The ICAP is the needs base assessment for the ROW. The ICAP determine the most appropriate supports level.

•The approvable POC must be approved within 90 days after linkage. An exception to this timeline will be made if housing cannot be secured with a reasonable time period.

•The LGE staff have ten working days in which to review the POC information, complete the precertification home visit and approve the POC prior to waiver services beginning. If Medicaid eligibility is delayed, then the LGE has 5 days from the date of receipt of the Medicaid eligibility determination to approve the POC. Waiver services cannot begin prior to the approved POC.
•The entire team meets at least annually or as needed to review and revise the POC for the upcoming service year

B. INITIAL ASSESSMENTS

The Office for Citizens with Developmental Disabilities (OCDD) has developed the a person centered framework for all activities related to planning for individualized supports and services. The activities below describe the discovery process in which the support coordinator assists the participant in developing a Plan of Care.

Discovery activities include:
1. A review of the participant's records relevant to service planning (i.e. school, vocational, medical, and psychological records).

2. Conducting a personal outcomes assessment, which assists the planning team in determining what is important to the participant and his/her satisfaction or dissatisfaction with different life domain areas.

3. A review of the Inventory for Client and Agency Planning(ICAP).

4. A review and/or completion of any additional interviews, observations, or other needed professional assessments (i.e. occupational therapist, physical therapist, or speech therapist assessments).

Information obtained through the discovery process is shared with the support team in preparation for the POC meeting. Discovery activities are summarized and conclude with the POC meeting.

Based on the findings of the discovery activities described above a POC is developed.

C. PLAN OF CARE (POC) DEVELOPMENT AND TIMING

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

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

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

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

The Support Coordinator is required to submit the complete initial Plan of Care to the appropriate LGE within sixty (60) days following linkage.

The LGE staff has ten (10) business days to review the information, complete the pre-certification home visit and approve the Plan of Care prior to waiver services beginning. If Medicaid eligibility is delayed, then the LGE has 5 days from the date of receipt of the Medicaid eligibility determination to approve the POC. Waiver services cannot begin prior to the approved POC.

D. ROW LEVEL ASSESSMENTS

The ROW level of care and budget level is determined by the ICAP assessment. The ICAP results indicate which ROW level of care and budget level the participant meets. There are four level of care and budget levels within the ROW. There are four levels, level 1 is least needs to level 4 which is highest needs. A comprehensive plan of care is developed utilizing the information obtained from the discovery process and the ICAP assessment.

Reassessments are conducted with significant life changes and at least annually. The assessment process should be ongoing and reflect changes in the participant’s life, needs, personal outcomes and preferences.

If the participant disagrees with the ROW level assignment, he/she or the family or authorized representative may present supporting documentation and request a re-assessment which could result in additional services. If the participant or the family or authorized representative is not satisfied with the decision, then an appeal may be made to the Louisiana Department of Health, Bureau of Appeals process as referenced in Appendix F-1, Opportunity to Request a Fair Hearing.

E. HOW PARTICIPANTS ARE INFORMED OF AVAILABLE SERVICES

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

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

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

Discovery, which involves gathering information about the participant's interests, goals, preferences, and support needs through assessments and interviews. The discovery process ends with the formulation of the participant's vision and goals.

Planning. This involves using the information from the discovery process to develop the Plan of Care. During the planning process, the support team works with the participant to develop strategies to assist him/her in achieving his/her goals and support needs. Strategies should identify all supports needed to assist the participant in achieving his/her goals and meeting other identified support needs and an appropriate action plan. For each personal outcome/goal identified, the support team will identify the following: the participant's strengths, skills, abilities that can be used to achieve his/her goals; challenges, barriers, health issues, or risk factors that can be deterrents to meeting his/her goals; strategies,

treatments, or trainings which can be implemented to overcome barriers; any opportunities available for increasing the participant's independence in achieving his/her goals.

Implementation, which involves the completion of noted strategies and provision of needed supports according to the participant's Plan of Care.

Review, which involves assessing if implementation occurred as planned, if progress was made toward reaching one's goals, and if positive changes have occurred as a result of the plan. The support team will assess the effectiveness of the strategies implemented and changes will be made as needed.

G. COORDINATION OF SERVICES

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

The participant's prioritized personal goals and specific strategies to achieve or maintain his/her desired personal goals. These strategies will focus first on the natural and community supports available to the participant and, if needed, paid services will be accessed as a supplement to natural and community supports.

An action plan which will lead to the implementation of strategies to achieve the participant's personal goals, including action steps, review dates, and the names of the persons who are responsible for specific steps.

Identified barriers, including health and safety risks, and specific strategies with timelines and the persons assigned to specific responsibilities, to address each issue.

All the services and supports the participant receives, regardless of the funding source which may include natural support networks, generic community services, and state plan services.

Identification of the frequency and location of services through a daily and alternate schedule.

Identification of providers and specification of the service arrangement.

Identification of the support team members who will assist the support coordinator in the planning process, as well as building and implementing supports for the participant.

Signature of all support team members present in the planning meeting to indicate their agreement with the Plan of Care.

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

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

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

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

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

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

During the quarterly monitoring reviews, the support team will review various data sources related to the participant's goals and objectives in order to determine if progress has been made.

I. HOW AND WHEN PLAN IS UPDATED

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

The Plan of Care must be updated at least annually or as necessary to meet the participant's needs. The completed, updated, annual POC must be submitted to the Support Coordination supervisor or LGE as defined in OCDD policy for approval. To be considered timely, the plan of care must be approved prior to the expiration of the previous plan of care.

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

Emergency revisions must be submitted by the support coordinator to the LGE as defined in OCDD policy within twenty-four (24) hours of discovery or by the next working day for approval. Revisions that include routine changes, such as planned vacations, must be submitted by the Support Coordinator at least seven (7) working days prior to the change.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

In addition, information gained during interviews with the participant, his/her legal representative(s), and support team members, as well as information from the LGE pre-certification visit is also used during the initial planning process to identify potential risks to the participant.

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

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

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

BACK-UP STAFFING PLANS

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

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

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

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

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

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

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

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

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

EMERGENCY EVACUATION PLANS

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

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

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

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

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

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

Establishment of effective lines of communication and chain-of-command, and procedures for dissemination of Emergency Response Plan to participants and Support Coordinators; and

Protocols outlining how and when direct support staff and participants are to be trained in Emergency Evacuation Response Plan implementation and post-emergency protocols.

Training for direct support staff must occur prior to any worker being solely responsible for the support of the participant, and participants must be provided with regular, planned opportunities to practice the emergency evacuation response plan.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Service plans are subject to approval by the State Medicaid Agency (SMA). The SMA does not review and approve all service plans prior to implementation; however, all are subject to SMA’s approval. The SMA completes reviews of participant records on a routine basis. Information reviewed includes, but is not limited to: development of an appropriate individualized person-centered service plan, completion of updates and revisions to the service plan, and coordination with other agencies as necessary to ensure that services are provided according to the service plan.

Medicaid Program Support and Waivers (MPSW) section staff has access to the Louisiana Support Coordination Application (LASCA) database which houses results of annual monitoring of Support Coordination Agency performance. These performance results include determinations of level of performance on service plan development, implementation, and service delivery. MPSW compares support coordination service plans and corresponding monthly Support Coordination Documentation (SCD) obtained from the support coordination agency with LASCA results to validate the support coordination monitoring process and to ensure participant’s health and welfare. If discrepancies are identified, the Medicaid HCBS Oversight Committee addresses the discrepancies and determines actions necessary to resolve them on a systemic level, e.g. training or policy revision.

The State utilizes a composite sample of all plans in that review period and the sample is calculated using a 95% confidence interval. The frequency of these reviews are annually with a proposal to complete quarterly reviews.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the

appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

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

Specify the other schedule:

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

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

Specify:

Direct Service Provider agency

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

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

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

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

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

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

Revisions to the Plan of Care reflect the results of the monitoring. During the monitoring of the Plan of Care implementation, if changes are needed, a revision to the Plan of Care will be completed. All revisions must be reviewed and prior approved by the Support Coordination Supervisor or LGE as defined by OCDD policy . Emergency revisions to the Plan of Care must be submitted to the LGE as defined by OCDD policy within 24 hours or next business day. Routine revisions must be submitted to the LGE as defined by OCDD policy within at least seven (7) days prior to the change.

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

b. Monitoring Safeguards. *Select one:*

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
D.a.i.c.2 Number and percentage of participants whose plans of care were reviewed and revised to address changing needs. Numerator: Number of plans of care revised to address changing needs / Denominator: Total number of participants whose

quarterly contact indicated a changing need.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
D.a.i.d.1 Number and percentage of participants who received all types of services specified in the plan of care. Numerator = Number of participants who received all types of services specified in the plan of care; Denominator = Total number of participants.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
D.a.i.d.2 Number and percentage of participants who received services in the scope, amount, frequency and duration specified in their plan of care. Percentage = Number of participants who received services in the scope, amount, frequency and duration specified in their plan of care / Total number of participants.

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

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

Medicaid Data Contractor		
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.a.i.e.2. Number and percentage of waiver participants with a valid signature, defined as the participant's/authorized representative's signature, on the plan of care which verifies that available services were discussed with the waiver participants. Percentage = Number of participants with a valid signature on the plan of care / Number of participants reviewed in the sample.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
D.a.i.e.1. Number and percentage of waiver participants with a valid signature defined as the participant's/authorized representative's signature, on the plan of care which verifies that the freedom of choice was offered among waiver providers. Percentage = Number of waiver participants with a valid signature on the plan of care / Total number of participants reviewed in the sample.

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

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

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

Data Aggregation and Analysis:

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

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

For all performance measures except D.a.i.c.1(Updated prior to plan expire), D.a.i.d.1, and D.a.i.d.2, LGE staff perform monitoring of support coordination agencies at least Quarterly and annually utilizing the OCDD Support Coordination Monitoring Tools: Participant Interview, Participant Record Review, Support Coordinator Interview, and Agency Review. The sample size will be large enough for a confidence level of 95% + or - 5%. The number of participants from the statewide sample to be included in each support coordination agency (SCA) sample will be proportional to the percentage of participants linked to each agency on the date the sample is generated. An SCA's sample size will be determined separately for each region in which the SCA operates.

For all performance measures except D.a.i.c.1, D.a.i.d.1 and D.a.i.d.2., the specific criteria for these measures are found in the OCDD Interpretive Guidelines for the OCDD Participant Record Review.

D.a.i.c.1 measures the first part of sub-assurance c., whether the service plan was updated at least annually. The Medicaid Data contractor is responsible for prior authorization of services and authorizes services based up receipt of an approved service plan. Data is then entered into the contractor data system which provides 100% representativeness for this measure.

D.a.i.c.2 measures the second part of sub-assurance c., whether service plans are updated when warranted by changes in the waiver participant's needs. The data source is the OCDD Participant Record Review and the responsible party for data collection/generation is the LGE.

D.a.i.d.1, and D.a.i.d.2: the Medicaid data contractor prior authorizes services according the approved service plan and enters post authorization of service once a provider has verified service delivery. This data is utilized to determine whether the participant received the type, scope, amount, duration, and frequency specified in the service plan. The method for validating this information is collected by the Support Coordination Agency during the quarterly reviews in the home and entered into the Case Management Information System (CMIS) which is accessed by the Medicaid Data Contractor to validate if the services have been delivered in the type, amount, frequency, duration, of services identified in the plan of care. The Support Coordination Agency and the LGE reviews the data quarterly for these measures.
Regarding D.a.i.e.1 and D.a.i.e.2, a valid signature on the service plan is either the signature of a participant with the capacity to approve the plan or a person who has been designated on the OCDD Authorized Representative Form as such.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

D.a.i.c.1: The LGE receives quarterly reports from the Medicaid Data Contractor for review. If the participant's annual Plan of Care (POC) was not submitted within the required timeline, the LGE will contact the support coordination agency. The support coordination agency will have 10 days to respond identifying why the plans of care were not timely submitted. Depending upon the scope and persistence of such problems, OCDD may pursue sanctions as outlined in the Support Coordination Performance Agreement including withholding payment.

D.a.i.d.1: The LGE receives quarterly reports from the Medicaid Data Contractor in order to review trends and patterns of under-utilization of services. If this appears to be an isolated event, the LGE will follow up with the support coordination agency to determine the reason and the support coordinator shall revise the POC as necessary. If the POC revision is not submitted within the timeframe, OCDD shall pursue sanctions as outlined in the Support Coordination Performance Agreement. If this appears to be widespread, the LGE will consult with OCDD State Office who will then bring the issue to the Performance Review Committee and the OCDD Executive Management team for review and resolution.

D.a.i.d.2: The LGE receives quarterly reports from the Medicaid Data Contractor in order to review trends and patterns of under-utilization of services. If the LGE discovers under-utilization due to a particular agency, among certain services, lack of availability of services, etc., the LGE will consult with OCDD State Office who will then bring the issue to the Performance Review Committee and the OCDD Executive Management Team for review and resolution.

The State's method for addressing individual problems identified through the remaining performance measures is as follows: LGE staff perform monitoring of Support Coordinator Agencies (SCA) at least annually utilizing the OCDD Support Coordination Monitoring Tools: Participant Interview; Participant Record Review; Support Coordinator Interview; and Agency Review. The processes for scoring and determining the necessity for corrective actions are located in the "Updated Guidelines for Scoring, Corrective Action and Follow-up Monitoring." After all elements are assessed and scored, the LGE reviewer documents the findings, including the Statement of Determination which delineates every POC remediation required and required responses/plans of correction expected from the SCA. Based on the scope and severity of findings, the SCA is assigned a Statement of Determination at Level I, Level II, or Level III. The LGE office and/or State Office follow-up according to timelines associated with each level to ensure that plans of correction are implemented and effective. Level III determinations are those having the actual or potential for immediate jeopardy. In these cases, the SCA must develop a plan of correction that includes the identification of the problem; full description of the underlying causes of the problem; actions/interventions that target each underlying cause; responsibility, timetable, and resources required to implement interventions; measurable indicators for assessing performance; and plans for monitoring desired progress and reporting results. In addition, OCDD takes enforcement action to assure the health and safety of participants. Actions include, but are not limited to: transfer of participants who are/may be in jeopardy; removal of SCA agency from the freedom of choice list; suspension of all new admissions; financial penalties; suspension of contract/certifications as a provider of SC services.

If a Plan of Correction, Progress Report and/or Follow-up Report remains unapproved by the time of the next annual review the agency placed on the next level with more stringent requirements. With a finding of satisfactory or a recommendation for improvement no remediation is required. These remediation activities will be documented through tracking events in the Support Coordination Monitoring database.

Training will be necessary when trends are detected in plans of care that do not address: participant goals, needs (including health care needs), and preferences; how waiver and other services are coordinated; and identification of responsibilities to implement the plan. The training requirements depend on the Support Coordination Monitoring findings and are based on the criteria found in OCDD Interpretive Guidelines for the OCDD Participant Record Review.

An unsatisfactory plan of care is one with criteria "not met" according to the OCDD Interpretive Guidelines for the OCDD Participant Record Review.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

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

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

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

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

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

Support Coordinators assist participants by providing the following activities:
The development of the participant's Plan of Care;
Organizing the unique resources the participant needs;
Training participants on their employer responsibilities;
Completing required forms for participation in Self-Direction;
Back-up service planning;
Budget planning;
Verifying that potential employees meet program qualifications; and
Ensuring participant's needs are being met through services.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

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

  Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

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

Specify the criteria

To be eligible, the participant must:

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

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

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

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

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Participants have the right to have a non-legal authorized representative perform the employer or managing employer responsibilities. The employer should live in the state of Louisiana and in closer enough proximity to be able to manage the needed day to day activities that a waiver provider would ordinarily preform. The support coordinator is responsible to ensure that the selected authorized representative agrees to fulfill the responsibilities of the employer or managing employer by ensuring the completion of the standard agreement form. If an authorized representative is desired by the participant, they must:

- Effectuate the decision the participant would make for himself/herself;
- Accommodate the participant, to the extent necessary that they can participate as fully as possible in all decisions that affect them;
- Give due consideration to all information including the recommendations of other interested and involved parties; and
- Embody the guiding principles of self-determination.

A participant may designate any person 21 years of age or older as an authorized representative unless a legal representative has been designated by a court or is otherwise limited by existing or pending legal action prohibiting someone from serving as an authorized representative.

An authorized representative may not receive payment for functioning as an authorized representative, nor may they receive payment for any waiver service provided to support the participant. The Employer/authorized self-direction representative and employee cannot be the same person.

The employer should act in the best interest of the beneficiary hiring staff to meet his/her needs providing safeguard against exploitation of the beneficiary.

The support coordinator must recognize the participant's authorized representative as a decision-maker, and provide the authorized representative with all of the information, training, and support the support coordinator would typically provide to a participant who is self-directing. The support coordinator must fully inform the authorized representative of the rights and responsibilities of an authorized representative in accordance with established procedures. The support coordinator must have the authorized representative review and sign a standard agreement form, which must be given to the authorized representative and maintained by the support coordinator. The agreement lists the roles and responsibilities of the authorized representative; asserts that the authorized representative accepts the roles and responsibilities of this function; and asserts that the authorized representative will abide by Medicaid Waiver policies and procedures.
Service plan monitoring takes place with each participant. Several questions on the standard service plan monitoring tool can prompt the identification of any issues with the authorized representative not acting in the best interest of the participant. Issues noted on the monitoring tool are addressed by Support Coordinators, LGE office and OCDD.

The support coordinator is required to address and report any issues identified with the authorized representative's performance including but not limited to compliance to Medicaid Waiver policies on incident reporting and report any incident of suspected fraud or abuse.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Waiver Service	Employer Authority	Budget Authority
Community Living Supports	☒	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and

integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

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

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

☐ **Governmental entities**

☒ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

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

The waiver service entitled:

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

Provide the following information

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

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

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

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

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

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

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

☐ **Maintain a separate account for each participant's participant-directed budget**

☐ **Track and report participant funds, disbursements and the balance of participant funds**

☐ **Process and pay invoices for goods and services approved in the service plan**

☐ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

Specify:

Additional functions/activities:

☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☐ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the

payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

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

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

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

If the participant decides that he/she would like to participate in this option, the support coordinator shall notify the LGE office and the Self-Direction Program Manager. Once notified by LGE office that the participant is eligible to participate in Self-Direction, the Support Coordinator facilitates the scheduling of the initial Self-Direction planning meeting.

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

The Support Coordinator will then facilitate planning and preparation of the Plan of Care/revision, which will be submitted to the LGE office for approval. Support Coordinator is responsible for monitoring service delivery and implementation dates, and updating the participant's Plan of Care annually or as changes in service needs occur. The Support Coordination supervisor or LGE office, as defined in OCDD policy, will approve changes as needed.

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

☒ **Waiver Service Coverage.**

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Adult Day Health Care	☐
Professional Services	☐
Respite Services - Out of Home	☐
Dental Services	☐
Support Coordination	☒
Monitored In Home Caregiving	☐
Supported Employment	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
One-Time Transitional Services	☐
Prevocational Services	☐
Community Life Engagement Development	☐
Nursing	☐
Transportation-Community Access	☐
Housing Stabilization Transition Service	☐
Environmental Accessibility Adaptations	☐
Financial Management Services	☐
Host Home	☐
Community Living Supports	☐
Day Habilitation	☐
Housing Stabilization Service	☐
Shared Living Services	☐
Assistive Technology/Specialized Medical Equipment and Supplies	☐
Personal Emergency Response System	☐
Companion Care	☐

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

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

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

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

All waiver participants have access to independent advocacy through the Disability Rights Louisiana (formerly the Advocacy Center)in Louisiana.
The Disability Rights Louisiana has a multi-disciplinary staff of lawyers, paralegals, client advocates and support staff who provide the following services: Information and Referral, Legal Assistance, Systems Advocacy, Outreach and Training, Legislative information and Education, and Investigations of Abuse and Neglect.

The Disability Rights Louisiana is Louisiana's protection and advocacy system. Federal law requires that a protection and advocacy system operate in every state to protect the rights of persons with mental or physical disabilities. The Disability Rights Louisiana serves Louisiana residents with physical disabilities, mental illness, intellectual disabilities, and traumatic brain injury. The Disability Rights Louisiana provides services to people with disabilities and seniors regardless of income.

The Disability Rights Louisiana helps to give individuals ability to gain access to skills and knowledge to act on their own behalf. The Disability Rights Louisiana provides a variety of booklets, reports, flyers, and other resources pertaining to persons 60 years or older and persons with disabilities. The Disability Rights Louisiana does not provide other direct services or perform waiver functions that have a direct impact on a participant.

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

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

Involuntary termination may occur for the following reasons:

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

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

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

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

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

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

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

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

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

If there is proof of misuse of public funds.

When action is taken to terminate a participant from Self-Direction involuntarily, the Support Coordinator immediately assists the participant in accessing needed and appropriate services through the ROW and other available programs, ensuring that no lapse in necessary services occurs for which the participant is eligible. There is no denial of services, only the transition to a different payment option. The participant and Support Coordinator are provided with a written notice explaining the reason for the action and citing the policy reference.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	278	
Year 2	305	
Year 3	333	

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 4	361	
Year 5	389	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

It is included in the FMS contract.

The cost of criminal background checks are paid for by LDH.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

As referenced in C-2a, the FMS is responsible for assuring that criminal background checks are conducted on all prospective self-direction employees. Once the FMS verifies that the employee has cleared the background check, the employee is approved to provide services.

- ☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- ☒ **Determine staff wages and benefits subject to state limits**
- ☒ **Schedule staff**
- ☒ **Orient and instruct staff in duties**
- ☒ **Supervise staff**
- ☒ **Evaluate staff performance**
- ☒ **Verify time worked by staff and approve time sheets**
- ☒ **Discharge staff (common law employer)**
- ☐ **Discharge staff from providing services (co-employer)**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☐ **Reallocate funds among services included in the budget**
- ☐ **Determine the amount paid for services within the state's established limits**
- ☐ **Substitute service providers**
- ☐ **Schedule the provision of services**
- ☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☐ **Identify service providers and refer for provider enrollment**
- ☐ **Authorize payment for waiver goods and services**
- ☐ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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

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

1) A finding by the office that the person does not qualify for system entry;
2) Involuntary reduction or termination of a support or service;
3) Discharge from the system; and/or
4) Other cases as stated in office policy or as promulgated in regulation.

The participant or his/her representative may request a reconsideration and present supporting documentation if he/she disagrees with the specific OCDD waiver offered as a result of the initial needs based assessment and person-centered planning process. If the participant disagrees with the reconsideration decision, he/she may request a fair hearing through the formal appeals process (Louisiana Department of Health, Division of Administration Law (DAL) process as referenced in in this appendix.

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

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

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

In accordance with 42CFR 431.206, 210 and 211, participants receiving waiver services, and their legal representatives are sent a certified letter with return receipt to ensure the participant receives it by the appropriate LGE providing 10 days advance and adequate notification of any proposed denial, reduction, or termination of waiver services. Included in the letter are instructions for requesting a fair hearing, and notification that an oral or written request must be made within ten days of receipt of a proposed adverse action by the LGE in order for current waiver services remain in place during the appeal process. If the appeal request is not made within ten days, but is made within thirty days, all Medicaid waiver services are discontinued on the eleventh day; services that are continued until the final decision is rendered are not billable under the Medicaid waiver. If the final decision of the Administrative Law Judge is favorable to the appellant, services are re-implemented from the date of the final decision. An appeal hearing is not granted if the appeal request is made later than thirty days following receipt of a proposed adverse action sent by the LGE. Once a request for an appeal is received, the LGE must submit the request to the Division of Administrative Law - Department of Health section no later than seven calendar days after receipt. A copy of the letter and the response/request is kept in the participant's record at the appropriate LGE.

During an appeal request and/or fair hearing the Support Coordinator provides:
Assistance as requested by the participant and his/her legal representatives;
Documentation in progress notes of the status of the appeal; and

Information the participant and his/her legal representatives need to complete the appeal or prepare for a fair hearing.

Anyone requesting an appeal has the right to withdraw the appeal request at any time prior to the hearing. The appellant may contact the Division of Administrative Law directly, or may request withdrawal through the LGE . Requests for withdrawal are kept in the participant's record at the appropriate LGE.

Louisiana Administrative Code Title 48, Part I, Subpart 3, Chapter Home and Community Based Service Provider Licensing Standards, Subchapter C, Admission, Transfer and Discharge Criteria, require
that enrolled providers of waiver services provide participants and their legal representatives notice in writing at least thirty days prior to the transfer or discharge from the provider agency with the proposed date of the transfer/discharge, the reason for the action, and the names of personnel available to assist the participant throughout the process. The enrolled provider of waiver services must also provide the participant and his/her legal representatives with information on how to request an appeal of a decision for involuntary discharge. A copy of the notice of intent to transfer/discharge, and information that was provided on how to access the appeal process is kept in the participant's record at the enrolled provider of waiver services physical location of business.

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

Fair Hearing regarding dental services refer to LA.0005- Section A Part IV E Grievances

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

LDH Health Standards Section (HSS) is responsible for receiving, responding to and determining the necessity of and/or scope of investigation for all complaints in which the allegations involve potential non-compliance of Home and Community Based (HCBS) licensing standards by the direct service provider.

The LGEs are responsible for receiving, reporting, and responding to customer complaints received for individual supported through the waiver in which the allegations involve alleged violations of waiver policy by the direct service provider and/or non-regulatory matters that are not handled by Health Standards.

Reference LA.0005 for Dental Benefit Plan grievance system.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Office for Citizens with Developmental Disabilities (OCDD) is responsible for receiving, reporting and responding to customer complaints received for people supported through their office including those supported through the ROW in which the allegations involve alleged violations of waiver policy by the direct service provider and/or non-regulatory matters that are not handled by Health Standards. A complaint is a concern, dissatisfaction, or dispute expressed through written or verbal communication or expressed through other means, such as assistive devices, regarding: care, supports and services, action or inaction of staff, department or agency requirement, regulation or policy or other circumstances affecting quality of care or quality of life, including allegations of rights of violations. Each OCDD entity including LGEs or State Office are responsible for receiving, reporting, and responding to customer complaints. Each OCDD entity is responsible for training their staff, participants, their families, and providers regarding OCDD's policy on complaints. A complaint may be made in person or by phone, fax, e-mail or mail to an OCDD entity. When a complaint is received by an OCDD entity the complaint is reviewed to determine if the complaint can be resolved by OCDD or if the complaint needs to be referred to another agency (Bureau of Health Services Financing, Protective Services, etc.) for action/resolution. The initiation of the complaint review and follow-up occurs within two business days of receipt of the complaint. Actions to resolve the complaint will be completed within fifteen calendar days of receipt of the complaint, unless an extension is granted. A written response describing the actions in response to the complaint, is mailed to the complainant within five (5) business days of the complaint resolution/action. OCDD entities will continue to follow up with other agencies regarding complaint action/resolution. All complaints are entered into a database for tracking of complaints and quality management purposes.

Each OCDD entity will utilize complaint data from the complaint database to conduct quality reviews. A sample size of complaints is reviewed based on the number of complaints received and resolved each quarter. The reviews shall include contacting the complainants to assure their satisfaction with the resolution. The reports generated from the complaints database shall be evaluated to identify trends and patterns for determining appropriate strategies for improving services. OCDD State Office shall conduct oversight activities to assure that OCDD entities comply with policy guidelines. At least five percent of the total complaints from OCDD entities are reviewed quarterly to assess whether the complaints were addressed according to requirements. Reports are evaluated to identify trends and patterns and to make recommendations for training, technical assistance or strategies for improving services.
The Health Standards Section (HSS) is responsible for the operation of grievance/complaints that involve the potential non-compliance of Home and Community Based licensing standards by the direct service provider.
• The HSS State Office maintains a toll free complaint line for receipt of complaints involving waiver participants as well as other home and community based services such as those provided through Medicaid State plan.
• The nature and scope of the complaint is at the discretion of the individual registering the complaint.
• The Health Standards toll free complaint line number, the LGE complaint line number and the number for protective services is printed on business cards, brochures, and fact sheet along with directions on what number to call depending upon the allegations being reported. It is given to participants and their legal representative(s) at intake by their support coordinator. During the pre-certification visit the LGE staff checks to make sure that the information has been given to them. The support coordinator reviews the information during quarterly face to face visits, and each year at the annual service plan team meeting, or whenever it is requested by the participant and his/her legal representative(s). A virtual meeting may be allowed if criteria is met as defined in the OCDD Policy and Procedures manual. If a virtual meeting is held, electronic verification is acceptable.
• HSS and LGE staff, as well as support agencies such as Families Helping Families distribute the HSS, LGE and protective services contact information when assisting participants and their legal representative(s). Direct service providers are also required to give the toll free numbers to all participants.
• Support coordinators are responsible for informing participants and their legal representative(s) initially, annually or whenever information about the system is requested that filing a grievance or complaint is not a pre-requisite or substitute for a Fair Hearing. LGE staff checks to make sure that this information has been relayed to them during the pre-certification visit.
• If LGE or State Office Staff is contacted by a participant/legal representative (s), other state agency, support coordinator or provider wishing to file a complaint, the entity staff will review and consider the information provided by the complainant and make a determination as to whether the complaint can be resolved by the LGE or whether additional action is required by HSS. If it is determined that there is evidence of non-compliance of the HCBS Licensing Standards, the LGE will refer the complainant to the HSS Complaint line within 24 hours.

HSS and the LGE triages all complaints in the following manner:
• Provider non-compliance licensing issues are resolved by HSS.
• Complaints identified as abuse, neglect, exploitation or extortion are referred immediately to the applicable protective services agency.

• All other types of complaints are referred to OCDD State Office for incident resolution. Complaints identified as critical events or incidents are investigated by the appropriate office within thirty days of receipt of such report.

• Pursuant to Louisiana Revised Statutes 40:2009.14 if the complaint involves provider non-compliance with HCBS licensing standards, HSS will investigate by on site visit or administrative desk review. A written report is sent to the complainant within 45 days of receipt of the completed investigation, if a response to the complaint is requested by the complainant.

Regarding dental services, please see LA.0005 Section A Part IV E Grievances.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Critical events or incidents that are required to be reported as required by Louisiana Revised Statute 14:403.2, which defines reporting criteria pertaining to any known or suspected abuse, neglect, exploitation or extortion, by the discoverer of the incident immediately upon discovery to the appropriate protective services agency for review and follow-up action are:

•Abuse (adult), as defined in Louisiana Revised Statute15:503.
•Abuse (child), as defined in Louisiana Children's Code, Article 1003.
•Exploitation (adult), as defined in Louisiana Revised Statute15:503.
•Extortion (adult), as defined in Louisiana Revised Statute 15:503.
•Neglect (adult), as defined in Louisiana Revised Statute 15:503.
•Neglect (child), as defined in Children's Code, Article 1003.

The following categories of incidents as defined in OCDD Operational Instruction #F-5: Critical Incident reporting, Tracking and Follow-up Activities for Waiver Services are required to be reported Statewide Incident reporting Management System(SIMS) by the provider or Support Coordinator:

- Death-determined by physician or coroner how issues the death certificate on all deaths are reportable
- Fall-occurs when the beneficiary is found on the floor or ground unintentionally or who comes to rest on the floor or ground unintentionally
- Involvement with Law Enforcement occurs when a participant, his/her staff, or others responsible for the participant's care, are involved directly or indirectly in an alleged criminal manner, resulting in law enforcement becoming involved
- Loss or Destruction of Home defined as damage to or loss of the participant's home that causes harm or the risk of harm to the participant.
- Major Behavioral Incident defined as an incident engaged in by a participant that is alleged, suspected, or witnessed by the reporter that can reasonably be expected to result in harm, or that may affect the safety and well-being of the participant
- Major Illness defined as any substantial change in health status, (suspected or confirmed) which requires medical treatment.
- Major Injury defined as any suspected or confirmed wound or injury to a participant of known or unknown origin requiring medical attention by a licensed health care provider.
- Missing-participant unable to be located
- Restraint Use defined as the application of a physical hold (personal restraints), mechanical device (mechanical restraint), and/or medication (chemical restraint) for the purpose of restricting or suppressing an individual's movement or preventing an individual access to their body.
- Medication Errors defined as the administration or self-administration of medication in an incorrect form, not as prescribed or ordered, or to the wrong person, or the failure to administer or self-administer a prescribed medication, which requires or results in medical attention by a physician, nurse, dentist, or any licensed health care provider.

The provider or support coordinator must create a critical incident report via the LDH incident reporting system by the close of the next business day after incident discovery.

The discoverer of suspected abuse, neglect, exploitation or extortion directed at a waiver participant must report the incident by telephone to the appropriate protective services hotline for entry into the protective services intake system.

The provider employee or Support Coordinator who discovers the incident must enter it into the LDH incident reporting system as directed in the OCDD Operational Instruction F-5.

The discoverer of any event that involves an OCDD waiver participant and meets the definition of one of the OCDD critical incident categories must either call in the incident or complete a hard-copy incident report and submit it to the Direct Service Provider or Support Coordinator to be entered into LDH incident reporting system as soon as possible, but no more than 10 business days after the discovery. The Direct Service Provider or Support Coordinator who receives the hard copy report must enter it in to LDH incident reporting system within 3 business days. A discoverer is defined as an employee of any support service for the waiver participant who receives reimbursement through the Medicaid waiver program, or an agent of the person who is participating in self-direction.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The state provides information to the participant, his/her family, authorized representative or authorized representative during initial waiver planning/certification and annually thereafter.

Abuse, neglect and exploitation is discussed with the participant and/or families or legal representative initially by the support coordination agency, the local governing entity, and the provider agency. During the initial planning process, participants receive information regarding their right to be free from abuse, neglect and exploitation and how to report suspected abuse, neglect, or exploitation or extortion.
Each participant and their legal guardian or authorized representative receives a copy of the OCDD Participant Rights and Responsibility form which contains the phone number to the Health Standards Complaint line and the OCDD Complaint Line, as well as the phone number to the different protective services agencies:(Elderly Protective Services (EPS), Adult Protective Services (APS) or Child Protected Services. CPS).

During the annual plan of care meeting process, the OCDD Rights and Responsibilities form is reviewed and discussed, which includes a conversation regarding abuse, neglect, and exploitation. A copy of the OCDD Rights and Responsibilities form is given to the participant/family and is retained in the home. The form contains the phone number to the Health Standards Complaint line as well as the phone number to the different protective services agencies. (Elderly Protective Services (EPS), Adult Protective Services (APS) or Child Protected Services. CPS).

Additionally, on a quarterly basis, the Support Coordinator is required to conduct a face to face or virtual visit with the participant (and/or families or authorized representatives as appropriate). As part of the visit, the Support Coordinator ensures that the Health Standards Complaint line number, the OCDD Complaint Line number and the toll-free telephone numbers for other protective services agencies are available to the participant.

OCDD will make on-line training modules available for provider agencies, support coordinators and waiver personnel The modules will cover definitions of abuse, neglect and exploitation of minors and adults, the responsibility to report suspected abuse, neglect or exploitation, and the responsibilities of licensed providers and support coordinators to report, follow up and take corrective actions as deemed necessary by protective services. Initial and annual review attendance will be tracked by the OCDD Training Section.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

When a critical incident occurs, the following actions are taken:
Provider:
• Takes immediate action to assure that the participant is protected from further harm and must respond to any emergency needs of the participant.
•Enters critical incident report information into the incident reporting system by close of business the next business day after notification of a critical incident;
•The provider must review each critical incident and record remedial actions taken in response to the incident within twenty-four (24) hours of the discovery of the incident, including reports made to protective services or law enforcement.

•Cooperates with the appropriate protective service agency once an investigation commences if abuse/neglect/exploitation/extortion is reported. Supplies relevant information, records, and access to members of the agency conducting the investigation.
•Participates in planning meetings to resolve each critical incident or to develop strategies to prevent or mitigate the likelihood of similar incidents in the future.
•Tracks critical incidents and outcomes in order to identify remediation needs and quality improvement goals and to determine the effectiveness of strategies employed for incident resolution.

Support Coordinator:
•Monitors critical incidents entered into the incident reporting system by the provider on a daily basis;
Identifies and screens out reports that do not meet the criteria for critical incident.
•Contacts the DSP within two (2) hours of discovery if the incident is discovered by the Support Coordinator,
•Reports incidents involving abuse, neglect, exploitation, and extortion to Protective Services. Enters the critical incident into the LDH incident reporting system when Adult, Elderly or child protective services is involved.
•Enters follow-up case note by close of the sixth (6th) business day after initial report;
The Support Coordination Agency/ Support Coordinator is responsible for informing the waiver participants (or participant's family or legal representative, as appropriate) of investigation results due to abuse, neglect, and exploitation within (15) days after the final supervisor review and closure of an incident by the local governing entity.

•Continues to follow up with the DSP agency, the participant, the participant's guardian/authorized representative or natural supports, the LGE and any other entities involved, as necessary, and updates in the incident reporting system with case notes until the incident is resolved and the case is closed;
•Submits to the LGE a request for extension of open case in circumstances defined in OCDD Operational Instruction F-5;
•Convenes any planning meetings that may be needed to address remediation of the critical incident or develop strategies to prevent or mitigate the likelihood of similar critical incidents occurring in the future, and revise the POC accordingly;

•Sends the participant and DSP a copy of the Incident Participant Summary within fifteen (15) days after LGE waiver office final supervisory review and closure. The Summary will not include the identity of the reporter or any sensitive or unsubstantiated allegations. The Participant Summary is not distributed in the event of deaths;
•For transfer of open cases, the transferring support coordination agency must supply the accepting support coordination agency with the incident number(s) at the time of transfer of records. Additionally, the transferring support coordination agency must notify the accepting LGE. The accepting agencies must review, assign, take actions to resolve the incident, and enter into the case record in the incident reporting system until closure of the incident.
•Tracks trends and patterns of critical incidents to identify remediation needs and quality improvement goals and to determine the effectiveness of strategies employed.

Local Governing Entity (LGE):
•Reviews all new incoming critical incident reports in the incident reporting system on a daily basis, and assigns incidents to medical certification specialists within 1 business day for monitoring, follow-up and recommendation for closure when remediation of the incident is evidenced.

•Identifies critical incidents as defined in OCDD Operational Instruction F-8, Risk Management Process for Waiver Services: Critical Incident Reviews that have crossed threshold for any participant and refers cases to the OCDD Critical Review Committee (CIRC).
•Assures that all activities occur within required timelines as detailed in OCDD Operational Instruction F-5 and F-8;
•Provides technical assistance to the support coordinator when timelines are not being met or the support coordinator reports an inability to identify necessary resources. Assists in making referrals to additional referral resources as needed;

•Immediately reports the incident to the appropriate protective service agency if the LGE suspects or becomes aware that a critical incident meets the definition of abuse, neglect, exploitation or extortion, and there is no documentation that the allegation has been reported to the appropriate protective services agency;
•Conducts follow-up monitoring of a sample of critical incidents where remedial actions required revision of the plan of care;
•Closes critical incident cases all necessary follow- up has occurred and documented in the critical incident report,
•The LGE may grant extensions to timelines for closure to open incidents in categories as permitted in OCDD Operational Instruction F-5;
•Tracks trends and patterns of critical incidents to identify systemic remediation needs and quality improvement goals and to determine the effectiveness of strategies employed.
• Develops system improvement strategies to address identified needs of waiver participants, service providers, or other support systems as a result of identified trends or patterns.
•Conducts final closure of critical incident cases after all necessary follow-up has occurred and documented in the critical incident report, within thirty (30) days.
•Grants extensions to timelines for closure to open incidents in categories as permitted in OCDD Operational Instruction F-5.
• Tracks trends and patterns of critical incidents to identify systemic remediation needs and quality improvement goals and to determine the effectiveness of strategies employed.

Department of Children & Family Services/ Child Protective Services (DCFS/CPS): Investigates allegations or reports of abuse, neglect or exploitation by a family member or legal guardian involving a waiver participant aged 0-17 years, based upon CPS policies and guidelines,
•Develops a protective plan and retains the authority to remove the minor participant from the home setting for his/her safety. The LGE will coordinate continued waiver services contingent on CPS plan of protection.

Office of Adult & Aging Services/Adult Protective Services (APS) Investigates allegations of abuse, neglect, exploitation, or extortion involving a participant aged 18-59 when the alleged perpetrator is a family member, legal guardian, or other natural support person not employed by a licensed provider agency, based upon APS policies and guidelines.
APS develops a protective plan and retains the authority to remove the participant from the home setting for his/her safety. The LGE will coordinate continued waiver services contingent on APS plan of protection.

Elderly Protective Services (EPS):
Investigates allegations of abuse, neglect, exploitation and extortion involving a participant aged 60 or older when the alleged perpetrator is a family member, legal guardian, or other natural support person not employed by a licensed provider agency, based upon EPS policies and guidelines.
EPS develops a protective plan and retains the authority to remove the participant from the home setting for his/her safety. The LGE offices will coordinate continued waiver services contingent on EPS plan of protection.

Health Standards Section (HSS):
HSS investigates allegations or reports of abuse, neglect, exploitation, or extortion when the alleged perpetrator is a provider licensed agency owner or employee, based upon HSS internal policy and guidelines.
HSS determines the level of jeopardy to waiver participants, issues findings and deficiencies, and requires a plan of correction from the provider to remediate the conditions that caused the incident. The LGE office and support coordination agency will coordinate waiver services contingent on the plan of correction.

Law Enforcement:
•The provider and support coordinator are required to ensure that they contact law enforcement in the event of any allegation of child abuse or neglect involving participants under the age of 18. Protective services contacts law enforcement in the event of a substantiated case of abuse or neglect according to their policies and procedures.
•In the event of a participant's arrest for a crime, the provider and support coordinator contact law enforcement to assure that information about the participant's health needs, medications or other risk factors are conveyed to assure safety while in police custody.

OCDD State Office:
•Provides technical assistance to LGE when all attempts to mitigate harm have been exhausted;
•Collaborates with protective service agencies, Health Standards, law enforcement and the judicial system to assure

coordination of activities to mitigate harm in individual cases;
•Monitors timely closure of critical incidents and adherence to OCDD critical incident operational instructions by the direct service providers, support coordinators and LGE;
•Conducts Critical Incident Review Committee (CIRC) case reviews for participants who experience repeated critical incidents as defined in OCDD Operational Instruction #F-8 Risk Management Process for Waiver Services: Critical Incident Reviews. CIRC has the authority to issue recommendations for further action to providers, support coordination agencies and LGE when it is discovered that practices by any one or combination of these entities have not sufficiently assured mitigation of potential harm. CRC may, at its discretion, request a follow-up report on progress towards mitigation within 60 day timeline;
•Conducts Mortality Review Committee (MRC) meetings to analyze deaths of waiver participants, as described in OCDD Operational Instruction #F-1 Mortality Review for Waiver Participants. MRC has the authority to issue a request for corrective action to providers, support coordination agencies and LGE when it is discovered that practices by any one or combination of these entities could potentially affect other participants negatively. The MRC request for corrective action can be issued in conjunction with corrective action plans issued by HSS.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

OCDD is the State entity responsible for overseeing the operation of the incident management system.
A multi-agency Memorandum of Understanding between OCDD and LGE the day to day responsibility for oversight of the reporting and response to critical incidents or events that affect waiver participants.
OCDD maintains the services of support coordination agencies through contracts that stipulate the requirements for compliance with waiver regulations.

OCDD State Office Quality Section analyzes trends and patterns in critical incident reports to identify potential quality enhancement goals and utilizes the critical incident data to determine the effectiveness of OCDD Quality Enhancement strategies.

OCDD provides the State Medicaid Agency with aggregate quarterly reports which are used to identify trends and patterns.

The State Medicaid Agency oversees the maintenance and continual upgrading of the on-line critical incident reporting system.

Frequency of oversight activities:
The LGE, on a monthly basis, will pull a sample of critical incidents to review for adherence to policy including a review to determine if all necessary actions were taken to address and resolve critical incidents and perform annual analysis of data to determine the effectiveness of quality enhancement goals and activities.

The state uses critical incident reports to identify and prevent or reduce specific occurrences in the future by identifying trends and patterns, make recommendations for training, provide technical assistance and /or supports strategies to improve services. The LGE, on a monthly basis, will pull a sample of critical incidents to review for adherence to policy including a review to determine if all necessary actions were taken to address and resolve critical incidents and perform analysis of data to determine the effectiveness of quality enhancement goals and activities. The Direct Service Providers, Support Coordinators and LGE staff complete ongoing documentation and review of team meetings, discussions, referrals for additional services, and actual changes in the supports provided to the participant that occur as a result of the analyzed data in the critical incident.

OCDD State Office and the LGE jointly participate in the Human Services Accountability and Implementation Plan (AIP) to measure performance, report outcome measures and develop and implement quality enhancement strategies. LGE will report measures to OCDD quarterly and OCDD will conduct site visits to each LGE annually. The monitoring protocol and strategy for corrective action plans is described in OCDD Operational Instruction F-7: Quality Partnership: Reporting and Verification of Performance Measures and Quality Management Initiatives for Developmental Disability Services.

MPSW provides oversight and remediation enforcement of critical incident management through the Medicaid HCBS Oversight Committee which meets quarterly to review current performance reports for the all waiver assurances including health and welfare. Quality recommendations or issues which cannot be resolved at this level are placed on the agenda of the Medicaid/Program Offices Quarterly Meeting.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

LDH BHSF HCBS Providers Minimum Licensing Standards(LAC 48:I.Chapter 50) §5029 establishes prohibitions to the use of chemical restraints, physical & mechanical restraints, seclusion or any procedure which denies food, drink, visits with family, or use of rest room facilities. Enrolled providers of waiver services are required to ensure that non-intrusive, positive approaches to address the meaning/origins of behaviors are used prior to the development of a restrictive plan, & cover any behavioral emergency & provide documentation of the event in an IR format. Restraint is a reportable CI as described in OCDD OI F-5: Critical Incident Reporting, Tracking & Follow-up Activities for Waiver Services.

•It is the policy of the Office for Citizens with Developmental Disabilities (OCDD) to allow the use of restraints only when necessary to protect an individual or others from injury and at the direction of a treating professional who has considered all other less intrusive options to protect the individual/others.

• Restraints may only be used in response to a situation that represents an imminent and grave risk of injury to self or others and only when necessary as a health-related protection.
• The use of restraints that limit mobility or access is strongly discouraged and limited to use as a last resort when other methods have been determined to be ineffective in assuring health and safety.
• The use and type of restraints must be the least restrictive and intrusive to the person's dignity, liberty and autonomy that are effective in preventing injury.
• Restraints can only be used under written orders and supervision of a licensed treating clinician.
• Restraints that may be applied and monitored by provider staff are limited to the use of helmets, mittens, splints, bed rails or other equipment for the purposes of healing or protection from injury. All other medical restraints (i.e., use of a papoose board to complete a medical procedure) must be initiated by a physician or dentist (or their staff) in the physician/dentist's office/hospital under the supervision of the physician/dentist. No other forms of restraint, personal or mechanical, may be used in waiver services unless considered and approved under the requirements of section V.C. of this policy.
• Chemical restraints are prohibited in waiver services. All psychotropic medication must be prescribed by a treating licensed clinician to address a diagnosed behavioral health condition or specific target behaviors consistent with standard practice.

The following practices are prohibited:

• Restraints may not be used in lieu of appropriate treatment and/or behavioral supports, as coercion, discipline, punishment or for the convenience of or retaliation by staff.
• The use of prone containment (face down), horizontal physical holds, and multi-point mechanical devices to prohibit mobility are strictly prohibited within Waiver Supports and Services (WSS) settings.
• Restraints may not be used as part of a behavior support plan as a contingent consequence to effect a behavior change.
• The use of exclusionary time-out is strictly prohibited within WSS settings.
• The use of seclusion is strictly prohibited within WSS settings.

The State's method for detecting the unauthorized use of restraints is through the OCDD OI F-5: Critical Incidents Reporting, Tracking and Follow-up Activities for waiver services. All restraints are required to be entered into the LDH incidents reporting system. The provider must verbally notify the Support Coordinator of the critical incident as soon as possible after taking all necessary actions to protect the participant from harm and responding to the emergency need of the participant.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Providers are required to report measures implemented to mitigate the use of restraints and follow-up in regards to referrals to protective services (if necessary), changes to behavior supports, or staff training. The provider is responsible for reviewing incidents for trends and patterns within its own agency caseload to determine what quality initiatives may be necessary to provide alternate means of addressing situations which result in restraint at least quarterly.

The support coordination agency is responsible for tracking trends in restraint incidents involving providers who serve participants on the support coordination agency caseload at least quarterly. The support coordinator is responsible for addressing behavioral needs on a quarterly basis and amending the plan of care to ensure positive support strategies are implemented.

LGE are responsible for quarterly monitoring the reviews conducted by SCAs, to provide technical assistance and assist with referrals for additional services when necessary.

OCDD is responsible for reviewing aggregate data in the critical incident reporting system on the use of protective supports and procedures.

OCDD will present aggregate data to the OCDD Performance Review Committee to determine if any quality initiatives are necessary.

OCDD will provide MPSW with aggregate data and reports which are inclusive of any reported restraint use, remediation strategies and quality improvement initiatives and the results of quality improvement projects on a quarterly basis.

OCDD ensures that all applicable requirements are followed when there is misuse/ unauthorized use of restraint through review of LDH incident reporting system, complaints, Support Coordinator quarterly contacts with participants and families and Support Coordinator’s unannounced visits.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The State prohibits the use of restrictive interventions. The state strategies for detecting unauthorized use of restraints is through review of critical incident reports, complaints, support coordinator quarterly contacts with participants and families and support coordinator unannounced visits.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The State prohibits the use of seclusion. The state strategies for detecting unauthorized use of seclusion is through review of critical incident reports, complaints, support coordinator quarterly contacts with participants and families, and support coordinator unannounced visits.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

If the participant does not self-administer, or if medication is not administered by family, a registered nurse shall authorize and monitor medication administration and non complex task performed by the DSW in accordance with LAC 48:I. Chapter 92 May 20. 2019.

Medication administration can only be delegated to a DSW by an RN if the participant receives daily monitoring by a family member, direct service worker, and/or other health care providers for the purposes of collecting critical information needed to assure the individual's welfare. Additionally, the participant health status must be stable and predictable as determined by the RN.

The direct service worker attends to participants that receives periodic assessment by a RN based on the person's health status and specified within the plan of care; in no case shall the periodic assessment be less than annually. A comprehensive assessment performed for a client in accordance with policies and procedures established by Medicaid or by a LDH program office may serve as the basis of the RN assessment but may not be used in lieu of the RN assessment.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The LDH Office of Management and Finance, Health Standards Section conducts a survey/monitoring of provider agencies, which includes a review of participant's records. This review includes an assessment of services provided and their outcomes. Types of services reviewed include medications and treatments ordered by physicians and medication administration by unlicensed direct service workers. For every provider agency surveyed, HSS ensures all licensing regulations are followed for participants records reviewed, including medication administration. If citations are issued due to non-compliance, HSS issues a statement of deficiency and requires a corrective action plan.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Louisiana Department of Health Bureau of Health Services Financing Direct Service Worker Registry (LAC 48:I. Chapter 92) provides for general requirements for the performance of medication administration and noncomplex tasks.
The Support Coordinator is responsible for including medications, entity responsible for medication administration, and oversight into the participant's plan of care.

Unlicensed direct care staff that performs administration of medications or procedures may currently do so under Registered Nurse (RN) delegation. The RN signs a written document which indicates the participant's procedures, medications, dosages, site of administration and instructions. This document verifies that the delegating RN has provided specific training and instructions to the direct care staff concerning the listed medications and/or procedures, and verifies that they are acting under the RN's authority. Each provider agency's administration has the responsibility for conducting on-site visits and assessments of all employees delegated by the RN to give medications. They must also provide oversight when a person self-medicates.

In addition, the LDH-OCDD administers the Certified Medication Attendant Program which provides for the training and certification of unlicensed direct care staff through certified nurse instructors who are also trained by LDH-OCDD. These persons are trained to administer medications to persons with developmental disabilities. The state statute provides for the qualifications of the drug administration course and course applicants/participants and specifies authorized and prohibited functions for such certified provider personnel. This program is available to both waiver and institutional providers of developmental disabilities services.

Waiver provider personnel are mandated to have a minimum of 16 hours of training prior to working with a participant in addition to continued education per licensing regulations including Nurse Delegation training.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Medication errors are reported by waiver providers through the critical incident reporting system, which is accessed by the Health Standards Section and OCDD with follow-up for conducting corrective actions via the LGE staff and contracted Support Coordinators.

(b) Specify the types of medication errors that providers are required to *record:*

The administration of medication:
- In an incorrect form;
- Administered to wrong person;
- Administered but not as prescribed (dose & route);
- Ordered to the wrong person; or
- The failure to administer a prescribed medication.

If the error does NOT result in medical attention by a physician, nurse, dentist or any licensed health care provider, then the provider is required to record the error, but is not required to report the error to the State via the critical incident reporting process.

(c) Specify the types of medication errors that providers must *report* to the state:

Major medication incidents which include, the administration of medication in an incorrect form, not as prescribed or ordered to the wrong person or the failure to administer a prescribed medication, which requires or results in medical attention by a physician, nurse, dentist or any licensed health care provider must be reported to the State via the critical incident reporting process.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

LDH Health Standards Section (HSS) is the State agency responsible for monitoring waiver providers which includes the administration of medications for those clients included in the monitoring sample and to assure that there is no negative outcomes.

HSS identifies problems in provider performance through their licensing and survey reviews of all Medicaid enrolled direct service providers. This includes a review of medication administration records, policy, and reporting policy.
Medication errors are a reportable incident category in the OCDD critical incident reporting system. Direct service providers and support coordinators are responsible for reporting medication errors that result in the need for medical intervention for the participant, within timelines specified in OCDD operational instruction F-5. Resolution of the incident requires documentation of immediate actions taken by the direct service provider to assure health & safety of the participant as well as preventative actions that improve systemic performance within the direct service provider agency. Aggregate totals of medication errors are reviewed by the LGE office and OCDD Quality Enhancement Section on a quarterly basis to identify patterns. The OCDD Mortality Review Committee reviews all waiver deaths monthly and identifies any concerns regarding medication administration; unexplained errors on the part of direct service provider staff are referred to the HSS for investigation.

OCDD will disseminate reports to LGE office management and the OCDD Performance Review Committee. These reports will be used to identify potentially harmful practices and implement training, technical assistance, and policy/procedural changes to improve quality statewide. The OCDD Quality Enhancement Section reports findings to the Medicaid agency (BHSF) quarterly.

OCDD's discovery of medication errors and related concerns may surface at any time and result from the support coordinator’s and LGE’s ongoing, real-time reviews of critical incident reports (which include medication errors), from LGE on-site visits or support coordinators quarterly on-site reviews and monthly contacts with participants, and from direct complaints lodged by participants, families or other stakeholders which may be phoned into OCDD State Office or the LGE office. As these medication-related concerns surface, the LGE staff follow up to assure that appropriate corrective actions have been implemented by waiver providers. The LGE staff follow up to critical incidents involving medication is entered into the incident reporting system data base which is automatically accessible to the State Medicaid Agency (SMA) and Health Standards Section.

When discovery of medication-related critical incidents involve abuse/neglect, immediate jeopardy to participants, fraudulent claims or other serious licensing deficiencies, they are immediately reported to the respective LDH Bureau, Section or Program Office with legal authority to investigate, sanction, recoup or take other actions to protect waiver participants (i.e., Protective Services offices; Health Standards Section; BHSF/Program Integrity Section).
MPSW reviews aggregated critical incident reports from the operating agency on a quarterly basis to determine if they were resolved appropriately and timely and to determine trends and patterns that indicate further action by MPSW. MPSW also monitors the data reports to see if remediation activities were effective in improving data results from the previous time period. If remediation activities were not effective, the MPSW will meet with the operating agency to address any changes needed to remediation strategies in order to improve results. The MPSW will continue to follow up with the operating agency to evaluate remediation for effectiveness.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
G.a.i.a.1. Number and percent of abuse, neglect, exploitation, and unexplained death investigations that included evidence of effective resolution and preventative measures. Numerator = Number of investigations that included evidence of effective resolution and preventative measures; Denominator = All investigations completed and transferred to waiver staff

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
G.a.i.b.1. Number and percentage of critical incidents where all follow-up was

completed and proper actions were taken as measured by closure of the critical incident within OCDD's specified timelines. Numerator = Number of critical incidents with completed follow-up and proper action were taken as measured by closure of the critical incident; Denominator = Total number of critical incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Reporting System

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
G.a.i.c.1 Number & percent of reported use of restrictive interventions/seclusion or use of restraint where a prevention plan has been developed as a result of an incident. Numerator= Number of restrictive interventions/seclusion where a prevention plan has been developed as a result of an incident. Denominator= total # of incidents reporting use of restrictive interventions or seclusion

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Reporting System

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

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

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
G.a.i.d.1 Number and percent of participants who received the coordination and support to access health care services identified in their service plan. Numerator = Number of participants who received the coordination and support to access health care services identified in their service plan; Denominator = Total number of participants reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% =/-5%

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

Data Aggregation and Analysis:

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

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

Support coordination agencies periodically conduct unannounced visits to participant homes. If a concern is identified during the unannounced visit, then the LGE office is notified by the SCA, and the LGE office may request a plan of correction from the provider agency.

If a complaint is received by OCDD or the LGE that has the potential to affect the health and welfare of a participant then the Support Coordinator is notified to conduct an unannounced health and welfare check of all waiver participants served by the direct service provider. If additional problems are discovered that affect the health and safety of participants, then a complaint is reported to the Health Standards Section for follow-up.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 Performance Indicators G.a.i.a.1, G.a.i.a.2, G.a.i.b.1, G.a.i.c.1
There are several layers of remediation to address the issues identified in a Critical Incident Report (CIR). They include:

- Primary remediation occurs at the level of the provider agency, where immediate response is required in halting and correcting harmful, dangerous or potentially harmful or dangerous conditions at the time the condition is discovered.
- The support coordinator is responsible for determining any further remediation that can be implemented by way of strategies developed in team meetings with the participant and auxiliary support services
- The LGE offices are responsible for reviewing individual critical incidents on a daily basis involving death, attempted suicide, and major illness resulting in hospitalization for pneumonia, bowel obstruction, and uncontrolled seizures and assuring that support coordinators follow through as described in the previous paragraph. The LGE office provides technical support to support coordinators as necessary.
- OCDD State Office Quality Section conducts individual reviews of incidents involving waiver participants that meet the threshold for involvement at that level as required in OCDD policy. OCDD State Office generates recommendations to the LGE office where each participant resides to further assist in remediation. All critical incidents are tracked for closure by OCDD State Office. If during the OCDD periodic review an the LGE fails to close a CIR within the appropriate timelines, then OCDD may request a Corrective Action Plan for improvement.

Performance Indicator G.a.i.a.1

- Remediation of individual cases of substantiated abuse, neglect or exploitation is determined by the appropriate protective services agency (dependent on the waiver participant's age) and/or the LDH Health Standards Section as required in their policies and procedures.

Performance Indicator G.a.i.a.2

- The OCDD conducts individual reviews of all incidents resulting in the death of the waiver participant through the Mortality Review Committee. OCDD may determine the provider and/or support coordinator could improve services, and require a corrective action plan. Follow-up corrective action is also documented in the case file.

Performance Indicator G.a.i.d.1
LGE staff perform monitoring of Support Coordinator Agencies (SCA) at least annually utilizing the OCDD Support Coordination Monitoring Tools: Participant Interview; Participant Record Review; Support Coordinator Interview; and Agency Review. The processes for scoring and determining the necessity for corrective actions are located in the "Updated Guidelines for Scoring, Corrective Action and Follow-up Monitoring." After all elements are assessed and scored, the LGE reviewer documents the findings, including the Statement of Determination which delineates every POC remediation required and required responses/plans of correction expected from the SCA. Based on the scope and severity of findings, the SCA is assigned a Statement of Determination at Level I, Level II, or Level III. The LGE office and/or State Office follow-up according to timelines associated with each level to ensure that plans of correction are implemented and effective. Level III determinations are those having the actual or potential for immediate jeopardy. In these cases, the SCA must develop a plan of correction that includes the identification of the problem; full description of the underlying causes of the problem; actions/interventions that target each underlying cause; responsibility, timetable, and resources required to implement interventions; measurable indicators for assessing performance; and plans for monitoring desired progress and reporting results. In addition, OCDD takes enforcement action to assure the health and safety of participants. Actions include, but are not limited to: transfer of participants who are/may be in jeopardy; removal of SCA agency from the freedom of choice list; suspension of all new admissions; financial penalties; suspension of contract/certifications as a provider of SC services.
If a Plan of Correction, Progress Report and/or Follow-up Report remains unapproved by the time of the next annual review the agency is placed on the next level with more stringent requirements. With a finding of satisfactory or a recommendation for improvement no remediation is required. These remediation activities will be documented through tracking events in the Support Coordination Monitoring database.
Training will be necessary when trends are detected in plans of care that do not address: participant goals, needs (including health care needs), and preferences; how waiver and other services are coordinated; and identification of responsibilities to implement the plan. The training requirements depend on the Support Coordination Monitoring findings and are based on the criteria found in the OCDD Participant Record Review for support coordinators.
An unsatisfactory plan of care is one with criteria "not met" according to the OCDD Participant Record Review for support coordinators.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The state of Louisiana utilizes a collaborative approach to develop and maintain the Quality Improvement System (QIS). The Medicaid agency in Louisiana, Bureau of Health Services Financing Medicaid Program Support and Waivers (BHSF/MPSW) has oversight for the implementation of Home and Community Based Services (HCBS) Waivers. The Office for Citizens with Developmental Disabilities (OCDD) is the operating agency, and the local operating arm for HCBS Waivers is the local Governing Entity (LGE). The LGE provides oversight and monitoring of the contracted support coordination agencies; the contracted support coordination agencies provide oversight and monitoring of service utilization. All of the above mentioned entities also work collaboratively with Louisiana protective services agencies, Health Standards Section (HSS) and/or law enforcement as deemed necessary. The process of trending, prioritizing and implementing system improvement activities are required on all levels with upward reporting to the operating agency for oversight and management of the Quality Improvement System including a summary of root cause analysis completed at each level and recommendations for design changes or other system improvements. This approach provides opportunities for continued communication and review of performance measures, discovery and remediation activities.
The Quality Improvement System (QIS) for the Residential Options Waiver (ROW) is part of a cross-waiver function of the Office of Aging and Adult Services (OAAS) and the Office for Citizens with Developmental Disabilities (OCDD). The purpose of the QIS is to assess and promote the quality of waiver programs serving older persons and adults with physical, intellectual and developmental disabilities. Additionally, beginning in 2018 with the amendment of the Residential Options Waiver (LA.0472.R01.04), OCDD began utilizing composite sampling and consolidated evidence reporting across its four developmental disabilities waivers in accordance with CMS' quality memo "Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers" released in 2014. These changes served to streamline monitoring, remediation, and reporting for all four waivers and results in increased efficiency to discovery methods and implementing systemic improvements.

The QIS assures a consistent and high standard of quality across waiver programs through:
- Adoption of common standards and performance measures against which waiver programs are evaluated.
- Development of policies, tools, practices, training, protocols, contracts and agreements that embody sound approaches to managing, delivering and assessing HCBS services and supports. To the extent possible, HCBS waiver policies and practices have shared purposes, language and expectations.
- Streamlining and consolidation of functions to strengthen the collection and analysis of timely and reliable data on waiver performance.
- A transparent system of reporting performance data for use by program managers, policymakers, consumers, providers, and other stakeholders.
- A structured and coordinated process to identify improvement opportunities, set priorities, allocate resources, and implement effective strategies.
- A coordinated approach for evaluating the effectiveness of the QIS in meeting program goals.

OCDD has a multi-tiered system for quality improvement. Each level (Direct Service Provider Agency, Support Coordination Agency, LGE, OCDD State Office, and BHSF) within the system is required to design and implement a Quality Management Strategy which is further described below.
Direct Service Provider and Support Coordination Agency Processes:
Direct Service Provider and Support Coordination Agencies are required to have a Quality Management Strategy that includes collecting information and data to learn about the quality of services, analyzing and reviewing data to identify trends and patterns, prioritizing improvement goals, implementing the strategies and actions on their quality enhancement plan, and evaluating the effectiveness of the strategies. At a minimum, agencies must review: 1) critical incident data, 2) complaint data, 3) data from case record reviews, and 4) interview/survey data from participants and families. The review process must include review by internal review team(s) composed of agency programmatic and management staff and an external review by the board of directors with stakeholder representation or a separate committee that includes stakeholders. Annually, agencies must submit to OCDD documentation to verify that they engage in ongoing, continuous quality review and enhancement activities.
LGE Processes:
The LGE is the operating arm for managing the Residential Options Waiver (ROW), and they are also required to have a Quality Management Strategy. This entity represents the primary source for discovery and remediation information regarding the waiver. They are required to collect information on performance indicators, conduct remediation as needed, aggregate data and review to identify trends and patterns and areas in which improvement is needed, and prioritize needed improvements. They are required to design and implement quality enhancement strategies and evaluate the effectiveness of those strategies. Each LGE has a Quality Specialist whose function is to facilitate data analysis and review. Within each LGE, data review is conducted by programmatic and

management staff and by the Regional Advisory Committee which is composed of stakeholders. OCDD State Office staff visit each LGE annually to validate the quarterly/annual data reported to State Office on performance indicators, to assure that remediation and system improvements occur as needed, and to provide technical assistance. When performance falls below the outlined measure, the LGE submits evidence to the operating agency, OCDD, with documentation of the quality improvement activities that have been implemented to improve performance. If the performance is not improved as outlined in the established benchmark, technical assistance will be provided to the LGE.

OCDD State Office Processes:

Aggregate data for waiver performance indicators are reviewed for trends and patterns on a quarterly or annual basis by the OCDD Waiver Section (program personnel) and Quality Section. These groups review data to ensure remediation is being completed by the LGE and to analyze the data for systemic concerns across waivers and across LGE's. Upon completion of the analysis, a representative from these teams presents data to the OCDD Performance Review Committee, with recommendations for system improvement. The OCDD Performance Review Committee is composed of designated members from each of the OCDD sections: Quality, Business Analytics, Clinical, Waiver, Early Intervention, and other members as designated by the OCDD Executive Management Staff. This provides the committee with expertise from several disciplines when reviewing recommendations. It also affords OCDD the opportunity to utilize existing expertise, processes, and tools to address new concerns, recommend strategies, and recommend systemic improvement that is best practice to ensure quality improvement and success. These recommendations are presented to OCDD Executive Management for consideration and approval. When significant system changes are proposed, the OCDD Core Stakeholder Group is convened and given the opportunity to review the proposed systemic changes and provide input regarding the recommendations. . The Core Stakeholder Group is comprised of waiver participants, families of waiver participants, advocacy groups, including the state DD Council, and a representative from the Governor’s office, and meets as needed based on system improvement activities. Recommendations, performance indicator data reports, and quality improvement initiatives status reports are also submitted to the Bureau of Health Services Financing (BHSF) on a quarterly basis.

BHSF/MPSW Processes:

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

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

-OCDD operating agency staff present their analysis of all performance measure findings, remediation activities, and systemic improvements to MPSW as defined in the 1915© waiver quality strategy

-MPSW Section Chief or designee indicates approval or disapproval of quarterly/annual data and activities;

-Based on evidence presented, MPSW staff provides technical assistance, guidance, and support to the operating agency staff;

-MPSW performs administrative oversight functions for OCDD HCBS program.

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

Ad Hoc Cross-Population HCBS Oversight Meetings – Additional meetings will be held jointly between MPSW, OCDD, and the Office of Aging and Adult Services (OAAS) on an as needed basis for the following purposes:

-Collaborate on design and implementation of a robust system of cross-population continuous quality improvement

-Present Quality Improvement Projects (QIP)

-Share ongoing communication of what works, doesn’t work, and best practices.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: Medicaid HCBS Oversight Committee	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

OCDD Process:
Following system design changes, data on performance indicators are reviewed by the Waiver and Quality program staff, as well as the OCDD Performance Review Committee to assure that the information is useful and accurate and to determine if performance has improved. Input is sought, as appropriate, from Support Coordination and Direct Service Provider Agencies, participants and their families, and other stakeholders, to determine whether the system design change is helping to improve efficiency and effectiveness of waiver supports and services. At this point, the Core Stakeholder Group may be convened, if needed, to address if system improvement has resulted from the system design/improvement activities.
BHSF/MPSW Processes:
Medicaid HCBS Oversight Committee – meets at least quarterly with the specific purpose to ensure proper oversight of the OAAS and OCDD operated HCBS Medicaid programs. Goals are to review current performance reports, determine need for new activities concerning quality and oversight in waiver programs, and ensure adequate remediation enforcement. Quality recommendations or issues which cannot be resolved at this level are placed on the agenda of the Medicaid/Program Offices Quarterly Meeting. Oversight members include HCBS quality management staff from MPSW and OCDD and the committee is chaired by the MPSW Section Chief or designee. The committee meets at least quarterly with the following standing agenda items:
-OCDD operating agency staff present their analysis of all performance measure findings, remediation activities, and systemic improvements to MPSW as defined in the 1915© waiver quality strategy
-MPSW Section Chief or designee indicates approval or disapproval of quarterly/annual data and activities;
-Based on evidence presented, MPSW staff provides technical assistance, guidance, and support to the operating agency staff;
-MPSW performs administrative oversight functions for OCDD HCBS program.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Medicaid Program Support and Waivers Section works in collaboration with the operating agency, OCDD, to periodically review the quality improvement strategies. Meetings are held to review and evaluate the performance indicators, discovery methods, remediation strategies, systemic issues, policies, procedures and any other issues that have surfaced as a result monitoring activities. Technical assistance is provided to the operating agency as needed by Bureau of Health Services Financing Medicaid Program Support and Waivers (BHSF/MPSW).
The operating agency, OCDD, has a Performance Review Committee which meets at least quarterly and provides ongoing oversight and management of the Quality Improvement System.
OCDD participates in the annual National Core Indicator (NCI) surveys which are addressed to a random sample of participants and families of participants to gauge their satisfaction with OCDD waiver services, and with the performance of support coordinators, LGE and providers. OCDD aggregates findings to identify areas of concern in service delivery in order to initiate quality improvement strategies.
Findings from this annual review will be analyzed by the Performance Review Committee to revise the QIS. Modifications may be made to quality standards and measures, data collection tools and methods, report formats documenting performance, or dissemination strategies for sharing performance data. New priority projects may be identified to better align the QIS to the needs of waiver managers, LGE, program staff, support coordinators and providers and, most significantly, to improve desired outcomes for HCBS waiver participants. The modifications and priorities identified by the Performance Review Committee will be implemented or facilitated by the OCDD Quality Enhancement Section.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ◉ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

Electronic Visit Verification (EVV), electronically verifies service visit occurrences and documents the precise time services begin/end via web-enabled smart devices. The purpose of EVV is to verify individuals receive services authorized in their plans of care, reduce inappropriate billing/payment, safeguard against fraud and improve program oversight. The state contracts for its EVV solution and has an open system for providers. If a provider elects to use their own system instead of the state-sponsored EVV system, the provider and vendor must first complete testing with the state to demonstrate that they can transmit all required EVV data elements to the state. EVV is required for in-home personal care services (Community Living Supports). The state defines compliance for EVV using a utilization threshold assessed over a 90-day look back period. If a provider doesn't meet the utilization threshold, the provider receives an alert message listing all non-EVV records. Non-EVV records outside of the allowed error rate will be blocked for payment until the provider reaches compliance (i.e. meets the EVV utilization threshold). Once compliance is reached, previously blocked service units will be released for payment. Providers who are routinely out of EVV compliance may be subject to further action including, but not limited to fines and sanctions.

All Medicaid providers will be required to fulfill requirements under the provision of the Single Audit Act to maintain Medicaid enrollment. The Louisiana Legislative Auditor (LLA) is the entity responsible for conducting periodic independent audits of the waiver program under provisions of the Single Audit Act. Medicaid staff will ensure that any provider receiving the amount of funds specified in the Single Audit Act will be required to provide a copy of the independent audit for continued Medicaid enrollment on an annual basis. Disenrollment will occur as a result of non-compliance. Program Integrity's Surveillance and Utilization Review (SUR) Unit is responsible for conducting post-payment reviews of all fee-for-service Medicaid providers. The post-payment review process used by the Program Integrity (PI) Section within the Louisiana Department of Health (LDH) is described in the Louisiana Surveillance and Utilization Review Subsystem (SURS) Rule and the Medical Assistance Program Integrity Law (MAPIL). The SURS Rule is available online through the Louisiana Register at the following website address: http://www.doa.la.gov/osr/reg/1211/1211.pdf (Pages 97-111 of the pdf or 2774-2788 of the hardcopy). Specifically the rule may be found through the following citation: Louisiana Administrative Code 50:I.Chapter 41.Waiver providers are selected and profiled. Providers meeting the exception criteria in the Surge run are screened/reviewed. Cases on Waiver providers are derived from multiple sources such as ad hoc data mining, Surge by Region run, HCPCs Outlier run, projects (such as services billed while the recipient is in the hospital) and complaints. Complaints are received via mail, fax, website and hotline. Sources for cases come from complaints, referrals (internal and external) and data mining (regularly scheduled data runs and ad hoc data runs). A team made up senior analysts and a supervisor triages all complaints. Onsite visits are determined on a case by case basis and depends on the severity of the complaint. If a provider does not make available documentation requested for a review, SURS analyst may be instructed to perform an on-site. If multiple complaints are received on the same provider, an on-site review may be the method of retrieving documentation. A random sample of recipients is selected or a specific recipient may be addressed depending on details of the complaint or reason(s) for the case opening. Sample selection uses a univariant sampling technique which allows all recipients equal chance of being selected. There is no weighting of recipients due to number of claims, amount paid, or any other factor. Generally, a scientific sample of 20 recipients is used. The basic logic for the scientific sampling process is:
1) A universe of claims/encounters is defined and claims/encounters meeting selection criteria are extracted.
a. Some criteria can be Provider ID, Proc Codes, Medicare coverage, or other identifying claim/encounter characteristic.
2) The universe is read and each of the unique recipient ids are extracted.
3) Each unique recipient id is assigned a "uniform" random number using SAS built-in UNIFORM () function. This is to ensure each recipient will have an equal chance of being selected.
4) Recipients are sorted using the random number, as to create a random listing of recipient ids.
5) Recipients with the lowest random numbers assigned are selected until the requested sample size is reached.
6) Claim/encounter records associated with selected recipient ids are extracted for reporting and analysis.

Documentation to support services billed are requested including timesheets, daily logs, etc. Additional info is also requested for direct service workers including employee records and any other associated documentation from provider agency. Complete copies of personnel files of all employees employed during the time period reviewed who provided care for recipients. This includes name, title, education level, job description, copy of employment application, driver's license, current address, criminal background check results, and all certifications and/or trainings.

The SURS data mining team produces computer runs generating open cases. Providers whose income spikes from one period to another are identified through exception processing and will generate case openings. Post-payment reviews are triggered when potential fraud, waste and abuse is identified either through a complaint, referral or data mining. SURS opens complaint cases throughout the year after the triage process. Some data mining runs (such as SURGE or Spike runs, date of death runs, outlier runs, etc.) are conducted on a fixed schedule. Other data mining runs are conducted on an ad hoc basis where project cases are opened and are usually policy-focused.

SURGE Run is a computer run produced on a regular basis identifying providers meeting a set of criteria and/or conditions. A run looks for providers with incomes that surge.
Providers are enrolled by LDH regions. Computer runs are done by region with a total of ten computer runs. There are nine in-state runs and 1out-of-state run. Runs are done monthly with the exception of the months of June and December. Providers are selected based on three criteria:
• the provider must be located in the region being reviewed
• the provider must have generated a minimum dollar amount paid in a twelve month period to be included for processing
• the provider must have had a "surge" in income from a six month period in one year to a six month period in another year.
SURGE by Region (SBR) Run: production run used to monitor activity of providers enrolled in the Louisiana Medicaid Program. The run identifies providers with a significant increase or "spike" in billing. The basic concept of the SBR run is to compare the provider's income for 6 months in a year to income for 6 months in the following year. The run is a valuable tool because any significant increase in provider's income is detected and a review of the provider's billing pattern is done to determine reasons for the change. Provider types are divided into three groups based on an income threshold: Group A=$75,000, Group B=$150,000 and Group C=$300,000. Providers in each group have to meet or exceed the minimum income threshold. Cases are opened using the following process:
•The SBR run is submitted in J-SURS according to the run schedule
•The run generates a list of providers meeting criteria or who except. Basic screening is performed on each provider on the exception list to determine if a case will be opened.
•Cases passing the screening are opened and tracked as a "SURGE" case type in SURS database.

When a SURGE case is opened, two reports are available to assist with case analysis: Individualized Exception Profile on Provider and Peer Group Data reports. Exception profile on the provider gives info specific to the individual servicing provider (dollar and claim averages per recipients, recipients by age and gender, reimbursements by dollar categories, percent changes, etc.) for six months in one year as well as metrics for six months in the following year. Top procedure codes paid and top diagnoses billed for individual servicing provider are displayed for each six month period. Peer group comparison run is done on provider type and specialty including a provider ranking by amount paid, top procedure codes paid, and top diagnoses billed. Reports deliver a comparison of the provider from 1 period to another period as well as a comparison of the provider to his or her peer group.

Ad hoc data runs are designed to look at more specific issues like waiver services billed while recipient is in the hospital or dates of service after a recipient's date of death or direct service workers employed who are excluded from participating in the Medicaid program.
A variety of professional staff are used to perform fraud, waste and abuse reviews. Analysts conducting reviews are primarily Registered Nurses (RN); however, there are dental hygienists and social workers on staff. In addition to the analysts, professional consultants are utilized such as physicians with different specialties, dentists, etc. Complaints are sent to the triage team, made up of professional staff who screen complaints for fraud, waste and abuse. If fraud, waste and abuse is involved, further research is done to determine if a comprehensive or focused review is done. Referrals are also made to professional licensing boards, local law enforcement, the Medicaid Fraud Control Unit (MFCU), child/adult protection, LDH program managers, etc. All SURS cases are worked by a professional staff analyst.

Once the review is completed by the analyst, the Quality Assurance (QA) team reviews the findings closely. Also, during the review process, medical consultants may give input as well as the PI Director and LDH program managers. After the case has completed the QA process, findings of the review are also reviewed by the RN Supervisors. From there, correspondence to the provider detailing results of the audit is presented by the RN Supervisors to the PI Director and manager. After the findings letter is sent, the provider is entitled to an informal hearing as well as an appeal hearing and judicial review. Once review findings have been confirmed and finalized, any overpayments due are collected. The provider receives a recoupment letter with specific areas of review. The provider has an opportunity to submit additional information, request an informal hearing with LDH or request an appeal. The provider can pay the overpayment amount in full or request a payment plan. In addition to recovering overpayments, SURS may request a corrective action plan to remedy the billing or programmatic issue identified.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
I.a.i.a.1. Number and percentage of waiver claims that are paid in accordance with the approved rate methodology. Numerator= Number of waiver claims paid in accordance with the approved rate methodology; Denominator= Total number of paid claims.

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

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

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

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
I.a.i.b.1 Number and percentage of rate changes that are approved by MPSW and consistent with the CMS approved rate methodology. Numerator= Number of rate changes approved by MSPW and consistent with the CMS approved rate methodology; Denominator= Total number of rate changes.

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

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States 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.*

I.a.i.a.1. BHSF determines all waiver payment amounts/rates in collaboration with OCDD, Division of Health Economics, and as necessary the Rate & Audit section. At the time of each requested rate change, MPSW and the Rate and Audit section reviews evidence that the rate adjustment was applied according to the methodology described in the waiver document. When a rate adjustment proposal is submitted without documentation which supports the current methodology it will not be approved and MPSW will offer technical guidance.
I.a.i.b.1 Upon annual review and analysis of all waiver claims payments through Medicaid Data Warehouse report generation, any discrepancies are resolved individually and systemically in collaboration with Medicaid Information Management Systems staff who oversee the Fiscal Intermediary.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

*Rates for the ROW are initiated by the OCDD w/ input from a group of interested parties,including but not limited to prvdrs &/or prvdr groups, participants,advocates,& Medicaid reps.OCDD's process for developing rates for ROW waiver services is based on rates for similar services in other waivers w/ review by Medicaid for appropriateness. The overall budget cap for each person in the ROW is stablished based on overall ICAP score. This allows flexibility for each indiv's plan to include an array of services needed w/in the overall budget cap.If Medicaid concurs that the rates are feasible, can be utilized w/in the indiv's overall budget & represent cost neutrality,then they are submitted to the Medicaid Dir. as part of the waiver application for final review & approval.Subsequently the reimbursement methodology is included in the Medicaid rulemaking process.This rulemaking process includes further opportunity for public comment. As rates are proposed for each service in the ROW, OCDD presents the rates & service definitions to the Medicaid liaison as part of the waiver application review.OCDD recommends rates to Medicaid based on the following hierarchy of factors:a)If there is a comparable service already existing in another OCDD program(waiver)that rate is mirrored.b)If there is no existing comparable service,OCDD explores the rates that are compatible w/ other similar services which are provided by Medicaid(i.e.nursing services).c)If no comparable Medicaid services & rates exists,OCDD explores services in the general community that are comparable & attempts to match the prevailing competitive rates.2.Based on the choices available in #1 above, OCDD recommends the service rate to Medicaid where it is reviewed & a determination made of the fiscal impact & budget availability for funding w/a final determination made on the service rate. ROW budgets follow the ICAP rates which were rebased & are developed w/in Medicaid. Therefore,the Medicaid Dir. has not only oversight, but direct control over the rate determination process.No rate can be implemented w/out the approval of the Medicaid Agency.Rates for each service are based on the following: *Adult Day Health Care(ADHC methodology for calculating each indiv component of the overall ADHC rate is a product of the median cost multiplied by an index factor.The resultant calculations provide reasonable & adequate reimbursement required to cover the costs of economic & efficient ADHC services.The base rate is calculated using the most recent audit or desk review cost for all ADHC prvdrs filing acceptable full year cost reports & includes the following components:a.Direct care-calculated at 115% of the median cost trended forward to rate year;b. Care related costs-calculated at 105% of the median trended forward to the rate year;c. Administrative & operating costs-calculated at 105% of the median trended forward to the rate year;d. Property/capital costs-calculated at the median cost;&e.Transportation costs-calculated for each based on their cost report. The cost report process is conducted yearly. Because of the wide variation in transportation cost,which is influenced by the rural or urban location of the ADHC center & the number of participants using the ADHC's transportation services versus other means of transportation (e.g.transportation provided by family, etc.),the transportation component of ADHC reimbursement is calculated & paid indivly to each ADHC center.Rates may be updated when additional funding is appropriated by the legislature using the most recent audited cost reports at that time. For inflationary increases the state uses various sources of data. For Administrative & operating cost component we use the CPI-All Items(South Region) index & for the Direct Care Cost Component we use the Consumer Price Index-Medical Services (South Region)index.*Community Living Supports (CLS), Community Integration Development & Out-of-Home Respite rates were negotiated based upon the estimated prvdr cost of rendering the service & similar services provided in other waivers. Cost of transportation is built into the CLS rate. When CLS is self-directed, the method of rate determination differs from when the service is prvdr managed. The prvdr-managed rate includes a cost component in addition to the rate paid for the services delivered. This additional cost component serves as an "administrative fee" which is payable to the CLS prvdr for exercising oversight, monitoring, & facilitating an agreement between the CLS prvdr & CLS worker. This cost component is absent when this service is self-directed. Otherwise, these rates for self-direction are initiated by OCDD & submitted to Medicaid in the same manner & in accordance w/ the same processes, including opportunity for public comment, as other service rates. In addition, Factor D charts in Appendix J of the ROW Application reflect a weighted average cost/unit for each year which includes the average of shared rates for CLS. *Professional Services & Nursing rates were based upon several factors:the cost to prvdrs to provide the service,the cost to secure the service in the community,the cost of similar services in current OCDD contracts,& state payment rates for FTemployees.*Services & rates for dental services were taken from an existing packaged plan of dental services as offered to Medicaid recipients under EPSDT, Pregnant Woman & Adult Denture programs.*LA considered the following factors in establishing its ROW day habilitation(DH), prevocational (PREVOC) services & supported employment(SE) rates as part of its negotiations w/ prvdrs & w/ input from other stakeholders:1)allowances for direct support worker(DSW) & other staff wages;2)the prvdr's overhead costs;3)transportation costs (per mile) from the vocational agency to all work sites; & (4) a profit margin for the prvdr. The rate allowed by the State for SE, DH, & PREVOC services take the following factors into consideration when determining the rate: wages (55%) administrative(10%);overhead,which includes costs for building, equipment, supplies, insurance, & gas (30%); & profit margin (5%).The value of the profit margin is consistent w/ & comparable to that of similar services provided in the community.The State's estimated profit margin is at 5% of the rate.The value of the admin & overhead costs are consistent w/ & comparable to that of similar services provided in the community.*Transportation rates for Community Access were based on transportation rates payable in other waivers.*

**PERS rates are based on the actual cost of providing the service. *One Time Transitional Services are paid at the cost of the provision of services w/ an annual cap. This cap was set based on historical cost allowed for providing the service in other waivers.*Environmental Accessibilities Adaptations & Assistive Technology/Specialized Medical Equipment & Supplies costs are based on historical expenditures for the services in waivers serving similar populations.*Companion Care(CC)rate is paid to prvdrs at a daily rate.This rate includes the cost of payment to the CC worker for services delivered plus an additional cost component payable to the CC prvdr for oversight, monitoring, & facilitating an agreement between the prvdr & Companion worker. The rate was based on the limited services expected to be provided, the anticipated users of the service & their level of need, plus an estimate of the amount of actual direct care service hours to be provided each day.*Host Home(HH) service are graduated according to level of need.The HH rates were determined by the increased complexity of the indivs' needs & the associated responsibilities of the HH dictated by the score on the ICAP.*Shared Living (SL) & SL-Conversion rates are based on several factors: employee costs, including wages & benefits; indirect costs such as transportation & administration; & staffing requirements & occupancy. All rates are graduated according to the intensity of the need of the indiv. SL rates were determined by the staffing level/ratio required for the increasing acuity level of the indivs being served. The greater the acuity level, the greater the amount of staffing needed. The acuity level was determined by each indiv's score on an ICAP. ROW per diem rates & annual budget amounts are calculated based on State Fiscal Year ICAP rates used to determine ICF/IID funding under four acuity levels of recipient needs (intermittent, limited, extensive & pervasive), minus applicable adjustments (prvdr fees & patient liability).ROW rates per acuity level are based on each participant's ICAP score & set the overall budget amount (or cap) a ROW participant must fall w/in when choosing an array of services & tailoring a support plan to meet indiv needs. Although the budget amounts set overall caps on expenditures per acuity level, there is much flexibility in choosing indiv services which have minimal to no caps placed upon them.*Support Coordination (SC)Services Rate is contracted monthly service rate paid to SC prvdrs. The monthly rate is based upon the average service utilization billed. The monthly rate reflects the cost of average units a nationally recognized rate-setting consultant who surveyed prvdrs relative to their time, activities performed, staffing requirements, general administrative & indirect expenses.*Housing Stabilization & Housing Stabilization Transition Service rates are based on the rate paid to SC agencies which employ indivs who have obtained a bachelors degree & are qualified to provide two levels of supervision. An agency trainer or nurse consultant who meets the requirements a support coordinator can also be reimbursed a per quarter rate for services provided.Admin support, travel & office operating expenses are included in the 15min billing rate.OCDD's process for developing rates for ADHC waiver services is based on rates for similar services in other waivers w/ review by Medicaid personnel for appropriateness.If Medicaid personnel concur that the rates are feasible & will help facilitate cost neutrality, then they are submitted to the Medicaid Dir.as part of the waiver application for final review & approval.Subsequently,the reimbursement methodology is included in the Medicaid rulemaking process.This rulemaking process includes further opportunity for public comment.All proposed rates are then factored into a cost projection & model to produce & estimated total program cost & average cost per recipient which is then used to determine the effects of these rates on program cost effectiveness. Rates are then renegotiated or changed as needed.*Monitored In Home Caregiving(MIHC) is based on Nursing Home daily rates. Level 1 was 40% of the average NH per diem (after subtracting the prvdr tax).Level 2 was 60% of the average NH per diem rate (after subtracting the prvdr tax).Payment rates are available to participants through prvdr agencies, support coordinators & agencies, as well as through publication in the La Register, the official journal for the state of LA. Participants may also receive information on service rates by contacting their LGE office. OCDD solicited public input from recipients, prvdrs, & advocacy organizations to determine rate, structure methodology, etc.This is accomplished through meetings w/ these entities around the state.The State used the existing rate for MIHC in the Medicaid system. However, basis of the rate will be adjusted to the average daily rate of the state's private intermediate care facilities (ICF-DD).Rate for level one will be 40% of that calculated rate & level two will be 60% of that same rate. The data for the calculation will come for the Medicaid MARS Data Warehouse for the state fiscal year. The average will be a simple calculation, total private ICF payments divided by the total number of unduplicated recipients.*

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Billings for waiver services provided to participants in the waiver program are submitted first to the Medicaid data contractor for post authorization. After services are authorized, providers bill directly to the Medicaid fiscal intermediary for payment.

For services utilizing Electronic Visit Verification (EVV), the state's data and prior authorization contractor has incorporated the EVV data collection within the Louisiana Service Reporting System (LaSRS). The state has set a compliance level for EVV. If a provider does not meet the compliance level, an alert message to the provider is generated and includes the total threshold percentage of all records counted against the threshold for the month. Providers who do not meet compliance, service unit payment will be blocked for services manually entered over the set allowance via the post authorization process. These service units will not be forwarded to Fiscal Intermediary claims for payment processing. Once the provider begins reporting services through EVV within the set allowance to meet EVV compliance, previously blocked service unit payment will be released for payment with these units being processed through Fiscal Intermediary claims processing. Providers who are routinely out of EVV compliance will not have their service units forwarded to Fiscal Intermediary for claims process and will also be subject to further action including, but not limited to fines and sanctions.
Self-direction time sheets are submitted to the agency with choice representative for processing. After time sheets are reviewed, all time records are submitted to the data contractor for post authorization of services. After prior authorizations are released, the agency with choice will bill the Medicaid fiscal intermediary for payment of all prior authorized and approved services. Payments for services rendered will be submitted to the agency with choice.

Billings for dental services are submitted directly by provider(s) to the Dental Benefit Plan/PAHP. The plan is required per contract to submit encounters to the State's MMIS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The Bureau of Health Services Financing (BHSF) utilizes a prior authorization and post authorization system maintained by a contracted entity to ensure that services provided to waiver participants are provided and paid for within the scope, duration, and frequency as specified in the approved plan of care. Electronic Visit Verification (EVV) is required for in-home personal care services. EVV is used to verify that individuals are receiving the services authorized in their plans of care, reduce inappropriate billing/payment, safeguard against fraud and improve program oversight. Medicaid eligibility for services is also checked and reviewed by the prior authorization entity.

Regarding dental services, each dental plan receives a monthly file from the SMA indicating which individuals are eligible to receive services and what services they may receive. Adult waiver participants enrolled with a dental plan are identified with a linkage type indicating their covered services.

Services are prior authorized according to the Plan of Care in quarterly increments and post authorized for payment after services have been rendered.

1. The prescribed services identified in the Plan of Care are entered in quarterly increments into the prior authorization system.

2. Upon the provision of services to the participant, the provider submits the service utilization data to the post authorization entity.

3. The post authorization entity checks the service utilization record against the participant's approved Plan of Care which identifies the prior authorized services.

4. Post authorization for payment is released to the Fiscal Intermediary when services are properly rendered to participants per the approved Plan of Care and prior authorization. However, for providers who have not met EVV compliance, service unit payment will be blocked for services manually entered over the set allowance via the post authorization process. Once the provider begins reporting services through EVV within the set allowance to meet EVV compliance, previously blocked service unit payment will be released for payment.

5. The provider then submits claims for approved services to the Fiscal Intermediary for adjudication and payment.

6. Services provided to participants that are not listed on the prior authorization system are rejected and ineligible for payment until all discrepancies are resolved.

In Program Integrity's SURS unit, cases are opened once a month; however, a case may be opened sooner depending on the priority or type of case. Some production runs are performed monthly and some are performed quarterly. Data mining is performed on a weekly basis, and projects are opened throughout the year. Complaints and internal referrals are received daily and are prioritized. The scope of a case may vary from being recipient-focused to a general review of the provider's billing, or it may be in-between as in limited to specific billing codes depending on what the evidence reveals.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ◉ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

  Dental Services paid by LA.0005-Dental services are the only waiver service not paid directly through the state MMIS. Dental providers will receive payment through their contracted PAHP and will not receive payments directly from the Medicaid agency. Each PAHP contracts with providers to deliver dental services utilizing a risk-based payment methodology. PAHPs are required to submit encounter data for each claim to the state's MMIS.

- ○ ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

- ☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***
- ☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***
- ☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

A fiscal/employer agent will provide fiscal management services to Self-Direction participants, as an administrative activity. Payments will be made to employees for direct services to the waiver self-direction participants related to the service Community Living Supports. The entities contracted to provide fiscal management services are Acumen Fiscal Agent and Morning Sun Financial Services.
Electronic Visit Verification (EVV) is utilized to verify that individuals are receiving the services authorized in their plans of care, reduce inappropriate billing/payment, safeguard against fraud and improve program oversight. EVV is required for in-home personal care services (Community Living Supports).
The fiscal/employer agent will process participants' employer-related payroll and withhold and deposit the required employment-related taxes. The State's fiscal/employer agent (FEA) for the self-direction program is enrolled as a Medicaid Provider. As a Medicaid Provider, the provider has access to the Medicaid Services Manual. Chapter one of this manual details general and administrative information including instructions on how to file claims/bill the State Medicaid Agency by the Medicaid Fiscal Intermediary.

Oversight is conducted through reports and since this is a contracted agent, oversight is conducted pursuant to all applicable state regulations for contracted services. Reports are submitted bi-weekly and include the amount paid to employee, amount of taxes withheld, and the employee rate of pay. These reports are reviewed to ensure the employee was paid appropriately.

☒ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Providers delivering dental services are paid through one on the State's contracted PAHPS. Reference LA.0005

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

The Louisiana State Legislature has re-named the OCDD Developmental Centers as Regional Service Centers in order to capture their current mission of providing a full range of community-based services. The OCDD Regional Service Centers will provide services to ROW waiver participants and will be paid for those services. Those ROW services will include shared living, supported employment, prevocational services, day habilitation, and professional services. These waiver services delivered by the Regional Service Centers are not located in institutional-based settings.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

◉ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Fixed rates for these services do not include any margin for room and board related expenses. The provider contracts specify that room and board expenses must be covered from sources other than Medicaid, such as consumer fees, donations, fund raising, or state funded programs. Providers of waiver services are contractually prohibited from billing for room and board expenses through Medicaid.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***

○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***

○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	37517.95	9419.70	46937.65	93722.70	5139.00	98861.70	51924.05
2	36433.97	9608.09	46042.06	95128.54	5241.78	100370.32	54328.26
3	37118.02	9800.26	46918.28	96079.83	5346.62	101426.45	54508.17
4	37812.93	9996.26	47809.19	96560.23	5453.55	102013.78	54204.59
5	38455.69	10196.19	48651.88	97043.00	5562.62	102605.62	53953.74

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	2000	2000
Year 2	2200	2200
Year 3	2400	2400
Year 4	2600	2600
Year 5	2800	2800

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

In developing estimates for the ROW, information from an existing CMS approved waiver was used as much as possible. The estimate for the average length of stay given for the ROW is based on La.'s data from the New Opportunities Waiver which serves a similar population.

Historical ALOS data from the ROW was also considered for estimates.

The factor D and D' prime estimates for WY 3-5 were based on data drawn from the state's Medicaid data warehouse for the anticipated population that would be eligible for transfer in addition to information for the existing ROW participants. The following data and sources were used:

- *Historical utilization and expenditure data for ADHC services.*
- *Historical utilization and expenditure data for personal care assistance services under CCW*
- *Historical utilization and expenditure data for state plan personal care services*
- *Historical utilization and expenditure data for support coordination services*

The original ROW application used the NOW average length of stay because of the similarities between the populations served by the two waivers. However, there is insufficient data in the ROW that would allow its own average length of stay calculation from the CMS 372 report to be used.
The current ROW average length of stay from the WY 5 2016-2017 CMS 372 is 311 days.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D estimates are based on the projected participants, service utilization, and proposed rates for each service under the waiver. Some of the utilization and costs per service assumptions were based on similar services in other waivers serving the population of persons with developmental disabilities. Services such as environmental modifications, specialized medical equipment, and other services similar to other waivers were considered in the assumption of utilization.

An estimated cost per service is derived by multiplying these estimates by actual service rates. This dollar amount is then totaled and divided by the number of unduplicated recipients for an average cost per recipient. A utilization inflation factor is thereby applied to each subsequent year based on program history and assumptions based on best professional judgment.The State identified nearly 260 persons who could possibly transfer from the Adult Day Health Care and Community Choices Waiver. OCDD analysts then used SAS to query the Medicaid MARS Data Warehouse to identify the waiver services along with long-term personal care services used by these individuals for a 24-month period. After establishing total annual services per recipient of each service, these services were cross-walked to the Residential Options Waiver. These total services were then combined with service data from the ROW 2016 or 2017 372 Reports and new utilization estimates were created. After setting the foundation for the base estimates, OCDD analysts along with programmatic experts made adjustments to these base estimates to accommodate expected changes in programmatic growth, changes in CMS approved waiver structures for the state, and increased demand for services previously under-utilized.
Under the state's CMS approved tiered waiver system, the state expects the ROW to experience large growth in the next few years. The estimates provided attempt to capture that growth in the number of unduplicated recipients of service.

Factors D and D' were derived from two data sources. The first source is the ROW 372 Report for 2016-2017. All of the existing ROW services were based on our Part X addendum for the 372 report that gives utilization data the feeds into the other sections of the standard report. There were two data sources used: CMS 372 Reports for 14-15, 15-16, and 16-17 and data from SAS Queries from the MARS Data Warehouse. This was the process used for each service estimate. Included is the basic spreadsheet that ultimately determines what information goes into Section J. Also included are the 372 Reports. The query data for this exercise is no longer available but included are the basic spreadsheets.All of the years were put into the utilization model and subsequent years were then used and averaged in.

Factor D estimates were based on the utilization percentages established for year one and only trended forward for the increase in unduplicated recipients. The utilization percentages are detailed on the provided spreadsheet. This increase is based on utilization of services by incoming waiver participants. Utilization of personal care service data for the incoming waiver program transition participants indicated an increase in CLS services based on their previous service usage. It is also anticipated that there will be an increase in future utilization of ROW recipients as more people enter into the program who would possibly have been in our New Opportunities Waiver. Individuals in the NOW have historically used greater amounts of personal care services than in the ROW. The state assumed that it would be prudent to reflect a greater amount of usage in Section J now with intent to examine the results as the waiver progresses through each waiver year.
For the individuals transferring to the ROW, data was used from the Medicaid MARS Data Warehouse. Utilization data was collected for a 24 month period starting July 2015 to June 2017 for the ADHC services, personal care assistance services, state plan personal care services, and support coordination services.

ADHC Service - The state looked at 24 months of claims data for the identified ADHC persons who were possible transfers to the ROW. The time period analyzed was LDH state fiscal years 2015 to 2017. The source of this information was the Medicaid MARS Data Warehouse

Personal care assistance services under CCW for those persons transitioning to ROW. -The state looked at 24 months of claims data for the identified OAAS-CCW persons who were possible transfers to the ROW. The time period analyzed was LDH state fiscal years 2015 to 2017. The source of this information was the Medicaid MARS Data Warehouse.

Historical utilization and expenditure data for state plan personal care services - The state looked at 24 months of state long-term personal care service claims data for the identified ADHC and OAAS-CCW persons who were possible transfers to the ROW. The time period analyzed was LDH state fiscal years 2015 to 2017. The source of this information was the Medicaid MARS Data Warehouse.

Historical utilization and expenditure data for support coordination services.The state looked at 24 months of support coordination claims data for the identified ADHC and OAAS-CCW persons who were possible transfers to the ROW. The time period analyzed was LDH state fiscal years 2015 to 2017. The source of this information was the Medicaid MARS Data Warehouse. Support Coordination services for persons in the ADHC waiver and the Community Choices Waiver are paid on a monthly basis. Support Coordination services in the ROW are paid in 15 minute increments. Since there was no one to one service equivalent, some assumptions had to be made as to how many 15 minute service units are actually used in the monthly rate of the ADHC and Community Choices Waivers. That estimated number of units was then added to the total units identified on Part X per ROW recipient and then divided by the estimated number of ROW unduplicated recipients to get the average number of units of service. That number was then multiplied by the cost per service to get the estimated total cost.

- *2015-2017 CMS 372 report for the ROW*

The state uses an in-state only document called Part X addendum to the annual CMS 372 report to estimate the utilization for ROW services. This sheet is not required by CMS and is not included with the submitted report. It creates a recipient, services, and payment by procedure code for each ROW service that is the basis for the numbers reported in the actual 372 report.

For Community Living Supports, the state used MARS Data Warehouse data for the previously mentioned 24 month period to estimate the total number of personal care units (PCA and PCS) used by the persons projected to be transferred from the ADHC and Community Choice Waivers. A historical monthly average utilization rate was calculated per person and then multiplied by the number of persons transferring to get a total number of units for the transferring group. The total units were then added to the total number of units identified on the Part X report and divided by the new estimated number of unduplicated recipients to get an average number of units per recipient. That number was then multiplied by the cost per service to get the estimated total cost.

Monitored In-Home Caregiving is a new service for the ROW, so there was no previous data to be considered in this making this estimate. Therefore, the state made reasonable estimates based on other daily rate programs and use of Companion Care in other waiver program. As the more information comes in, the State will adjust the numbers if needed to reflect more accurately the utilization.

The state increased the rate for Support Coordination in the ROW. The state also moved to a monthly payment platform for Support Coordination in the ROW from the previously used 15 minute increments.

Dental services were added effective 7/1/22 (WY 5). Rates are based on an estimated monthly capitation payment and assume a 3% growth rate annually. The growth/trend rate of 3% is the actual trend rate included in LA.0005 (Dental Benefit Program 1915b waiver) and is used for all capitated dental rates under the waiver. The trend was developed using a regression methodology and general industry trends. The number of users represents the total projected number of adult participants for the waiver year and factors in the average length of stay for the waiver. A monthly capitation payment will be paid for every adult each month they are enrolled in the waiver. Children are excluded from this estimate as they already receive comprehensive dental benefits through the State Plan EPSDT benefit.

All of our average cost per user is based on data pulled from the CMS 372 reports and data run from the Louisiana Medicaid MARS data warehouse. The State has seen some growth in these areas and the additional persons added to system reduces the average number of days of usage.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' is an estimate based on the actual participant expenditures for all other Medicaid services outside of waiver services. This dollar amount is totaled and then divided by the number of waiver participants to get an estimated average cost. A utilization inflation factor is thereby applied to each subsequent year based on program history and assumptions based on best professional judgment. Factor D' is calculated by taking the total non-waiver Medicaid expenditures for persons in the waiver and dividing it by the total unduplicated recipients in these facilities. We then apply a growth factor to represent the possible increase in cost due to various environmental and rate factors.

The State used data from existing waiver populations, with the assumption that these populations are comparable to the population served by ROW. Specifically, the population for this waiver will be existing ICF-DD participants, present and possible, as well as individuals on the DD Request for Services Registry. Therefore, the States dual eligibles will essentially be nearly the same or a similar population as identified in the Supports Waiver and NOW.

To exclude Medicare Part D Pharmacy cost from our cost effectiveness calculations we:

1. *Identified all ROW participants who had dual eligibility for Medicaid and Medicare services;*
2. *Developed an independent query to identify pharmacy related Part D acute care expenditures;*
3. *Based on these expenditures, an estimate for average annual Part D expenditure per participant was derived; and*
4. *Deducted this amount from the average acute care cost per waiver participant.*

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G is an estimate based on the actual Medicaid expenditures for all private intermediate care facilities for individuals with intellectual disabilities (ICF/IID). This dollar amount is totaled and then divided by the number of waiver participants to get an estimated average cost. A utilization inflation factor is thereby applied to each subsequent year based on program history and other factors. 2016-17 372 reports is the source for the state's estimates. The basis of the growth rate in Factor G has been changes in the per diem rate of the State's public and private ICF-DDs. We have accounted for this possibility by applying an inflationary factor on the subsequent years from the average cost calculated on the CMS 372 report.

The factor D and D' prime estimates for WY 3-5 were based on data drawn from the state's Medicaid data warehouse for the anticipated population that would be eligible for transfer in addition to information for the existing ROW participants. The following data and sources were used:

- *Historical utilization and expenditure data for ADHC services.*
- *Historical utilization and expenditure data for personal care assistance services under CCW*
- *Historical utilization and expenditure data for state plan personal care services*
- *Historical utilization and expenditure data for support coordination services*

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' is an estimate based on the actual Medicaid expenditures for all other Medicaid services provided to citizens residing in intermediate care facilities for individuals with developmental disabilities (ICF/DD). This dollar amount is totaled and then divided by the number of waiver participants to get an estimated average cost. A utilization inflation factor is thereby applied to each subsequent year based on program history and other factors. 2016-17 372 reports are the source for the state's estimates. These "other factors" refer to assumptions based on best professional judgement. The growth rate in Factor G' has been changes in the cost of Medicaid acute care services. Utilization and population mix generally account for the cost increase. We normally apply an inflation factor between 2 and 4 percent historically.

To exclude Medicare Part D Pharmacy cost from our cost effectiveness calculations we:
1. Identified all ICF/DD individuals who had dual eligibility for Medicaid and Medicare services;
2. Developed an independent query to identify pharmacy related Part D acute care expenditures;
3. Based on these expenditures, an estimate for average annual Part D expenditure per recipient was derived; and
4. Deducted this amount from the average acute care cost per ICF/DD individual.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Health Care	
Day Habilitation	
Monitored In Home Caregiving	
Prevocational Services	
Respite Services - Out of Home	
Shared Living Services	
Support Coordination	
Supported Employment	
Assistive Technology/Specialized Medical Equipment and Supplies	
Financial Management Services	
Community Life Engagement Development	
Community Living Supports	
Companion Care	
Dental Services	
Environmental Accessibility Adaptations	
Host Home	
Housing Stabilization Service	
Housing Stabilization Transition Service	
Nursing	
One-Time Transitional Services	
Personal Emergency Response System	
Professional Services	
Transportation-Community Access	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							**498096.52**
Adult Day Health Care	☐	15 minutes	43	3967.00	2.92	**498096.52**	
Day Habilitation Total:							**857103.04**
Day Habilitation	☐	15 minutes	132	2287.00	2.56	**772823.04**	
Transportation	☐	Per diem	43	98.00	20.00	**84280.00**	
Monitored In Home Caregiving Total:							**5092277.00**
Monitored In Home Caregiving-Level 2	☐	Per Diem	5	310.00	135.04	**209312.00**	
Monitored In Home Caregiving- intake and assessment	☐	one time	45	310.00	250.00	**3487500.00**	
Monitored In Home Caregiving-Level 1	☐	Per Diem	50	310.00	90.03	**1395465.00**	
Prevocational Services Total:							**51176.72**
Transportation	☐	Per diem	2	98.00	20.00	**3920.00**	
Prevocational Habilitation	☐	15 minutes	7	2446.00	2.76	**47256.72**	
Respite Services - Out of Home Total:							**47313.14**
Respite Services - Out of Home	☐	15 minutes	7	2042.00	3.31	**47313.14**	
Shared Living Services Total:							**1784250.00**
Shared Living Services	☐	Per Diem	100	305.00	58.50	**1784250.00**	
Support Coordination Total:							**3477459.30**
Support Coordination	☐	Monthly	1967	10.00	176.79	**3477459.30**	
Supported Employment							**857730.60**

GRAND TOTAL:	***75035903.63***
Total: Services included in capitation:	*2588227.77*
Total: Services not included in capitation:	*72447675.86*
Total Estimated Unduplicated Participants:	***2000***
Factor D (Divide total by number of participants):	***37517.95***
Services included in capitation:	*1294.11*
Services not included in capitation:	*36223.84*
Average Length of Stay on the Waiver:	*311*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Transportation	☐	Per Diem	25	172.00	20.00	**86000.00**	
Supported Employment	☐	15 minutes	94	2755.00	2.98	**771730.60**	
Assistive Technology/Specialized Medical Equipment and Supplies Total:							**1386.00**
Assistive Technology/Specialized Medical Equipment and Supplies	☐	Per Service	3	2.00	231.00	**1386.00**	
Financial Management Services Total:							**308704.49**
Financial Management Services	☐	Monthly	278	10.78	103.01	**308704.49**	
Community Life Engagement Development Total:							**1019189.01**
Community Life Engagement Development	☐	15 minute	129	1913.00	4.13	**1019189.01**	
Community Living Supports Total:							**47810560.00**
Community Living Supports	☐	15 minutes	1400	9280.00	3.68	**47810560.00**	
Companion Care Total:							**10076190.00**
Companion Care	☐	Per Diem	300	365.00	92.02	**10076190.00**	
Dental Services Total:							**2588227.77**
Dental Services	☒	Monthly	1967	10.22	128.75	**2588227.78**	
Environmental Accessibility Adaptations Total:							**161695.95**
Environmental Accessibility Adaptations	☐	Per Service	13	3.00	4146.05	**161695.95**	
Host Home Total:							**10990.00**
Host Home	☐	Per Diem	200	1.00	54.95	**10990.00**	
Housing Stabilization Service Total:							**1405.23**
Housing Stabilization Service	☐	15 minutes	3	31.00	15.11	**1405.23**	
Housing Stabilization Transition Service Total:							**2810.46**

GRAND TOTAL:	**75035903.63**
Total: Services included in capitation:	2588227.77
Total: Services not included in capitation:	72447675.86
Total Estimated Unduplicated Participants:	**2000**
Factor D (Divide total by number of participants):	**37517.95**
Services included in capitation:	1294.11
Services not included in capitation:	36223.84
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Housing Stabilization Transition Service	☐	15 minutes	3	62.00	15.11	2810.46	
Nursing Total:							243515.40
Nursing	☐	15 minutes	12	521.00	38.95	243515.40	
One-Time Transitional Services Total:							75000.00
One-Time Transitional Services	☐	Per Service	25	1.00	3000.00	75000.00	
Personal Emergency Response System Total:							30861.00
Personal Emergency Response System	☐	Monthly	127	9.00	27.00	30861.00	
Professional Services Total:							26442.00
Physical Therapy	☐	15 miniutes	13	24.00	13.75	4290.00	
Licensed Clinical Social Work	☐	15 minutes	13	24.00	7.50	2340.00	
Registered Dietician	☐	15 minutes	13	24.00	9.00	2808.00	
Psychology	☐	15 miniutes	13	24.00	31.25	9750.00	
Speech Therapy	☐	15 minutes	13	24.00	11.25	3510.00	
Occupational Therapy	☐	15 minutes	13	24.00	12.00	3744.00	
Transportation-Community Access Total:							13520.00
Transportation-Community Access	☐	Per Service	13	52.00	20.00	13520.00	

GRAND TOTAL:	75035903.63
Total: Services included in capitation:	2588227.77
Total: Services not included in capitation:	72447675.86
Total Estimated Unduplicated Participants:	2000
Factor D (Divide total by number of participants):	37517.95
Services included in capitation:	1294.11
Services not included in capitation:	36223.84
Average Length of Stay on the Waiver:	311

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							**556014.72**
Adult Day Health Care	☐	15 minutes	48	3967.00	2.92	**556014.72**	
Day Habilitation Total:							**943014.40**
Day Habilitation	☐	15 minute	145	2287.00	2.56	**848934.40**	
Transportation	☐	Per Diem	48	98.00	20.00	**94080.00**	
Monitored In Home Caregiving Total:							**1829551.40**
Monitored In Home Caregiving-Level 2	☐	Per Diem	5	310.00	135.04	**209312.00**	
Monitored In Home Caregiving- intake and assessment	☐	One Time	6	1.00	250.00	**1500.00**	
Monitored In Home Caregiving-Level 1	☐	Per Diem	58	310.00	90.03	**1618739.40**	
Prevocational Services Total:							**51176.72**
Transportation	☐	Per Diem	2	98.00	20.00	**3920.00**	
Prevocational Habilitation	☐	15 minutes	7	2446.00	2.76	**47256.72**	
Respite Services - Out of Home Total:							**54072.16**
Respite Services - Out of Home	☐	15 minutes	8	2042.00	3.31	**54072.16**	
Shared Living Services Total:							**1962675.00**
Shared Living Services	☐	Per Diem	110	305.00	58.50	**1962675.00**	
Support Coordination Total:							**3825735.60**
Support Coordination	☐	Monthly	2164	10.00	176.79	**3825735.60**	
Supported Employment Total:							**943269.60**
Transportation	☐	Per Diem	26	172.00	20.00	**89440.00**	
Supported Employment	☐	15 minutes	104	2755.00	2.98	**853829.60**	
Assistive Technology/Specialized Medical Equipment and Supplies Total:							**1386.00**
Assistive	☐					**1386.00**	

GRAND TOTAL:	**80154740.74**
Total: Services included in capitation:	2932813.37
Total: Services not included in capitation:	77221927.37
Total Estimated Unduplicated Participants:	**2200**
Factor D (Divide total by number of participants):	**36433.97**
Services included in capitation:	1333.10
Services not included in capitation:	35100.88
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Technology/Specialized Medical Equipment and Supplies		Per Service	3	2.00	231.00		
Financial Management Services Total:							**338686.58**
Financial Management Services	☐	Monthly	305	10.78	103.01	**338686.58**	
Community Life Engagement Development Total:							**1123896.90**
Community Life Engagement Development	☐	15 minute	141	1930.00	4.13	**1123896.90**	
Community Living Supports Total:							**53877824.00**
Community Living Supports	☐	15 minutes	1540	9280.00	3.77	**53877824.00**	
Companion Care Total:							**11083809.00**
Companion Care	☐	Per Diem	330	365.00	92.02	**11083809.00**	
Dental Services Total:							**2932813.37**
Dental Services	☒	Monthly	2164	10.22	132.61	**2932813.37**	
Environmental Accessibility Adaptations Total:							**186572.25**
Environmental Accessibility Adaptations	☐	Per Service	15	3.00	4146.05	**186572.25**	
Host Home Total:							**12089.00**
Host Home	☐	Per Diem	220	1.00	54.95	**12089.00**	
Housing Stabilization Service Total:							**1405.23**
Housing Stabilization Service	☐	15 minutes	3	31.00	15.11	**1405.23**	
Housing Stabilization Transition Service Total:							**2810.46**
Housing Stabilization Transition Service	☐	15 minutes	3	62.00	15.11	**2810.46**	
Nursing Total:							**263808.35**
Nursing	☐	15 minutes	13	521.00	38.95	**263808.35**	
One-Time Transitional Services Total:							**84000.00**
One-Time Transitional Services	☐					**84000.00**	

GRAND TOTAL:	**80154740.74**
Total: Services included in capitation:	2932813.37
Total: Services not included in capitation:	77221927.37
Total Estimated Unduplicated Participants:	**2200**
Factor D (Divide total by number of participants):	**36433.97**
Services included in capitation:	1333.10
Services not included in capitation:	35100.88
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		Per Service	28	1.00	3000.00		
Personal Emergency Response System Total:							**34020.00**
Personal Emergency Response System	☐	Monthly	140	9.00	27.00	**34020.00**	
Professional Services Total:							**30510.00**
Physical Therapy	☐	15 minutes	15	24.00	13.75	**4950.00**	
Licensed Clinical Social Work	☐	15 minutes	15	24.00	7.50	**2700.00**	
Registered Dietician	☐	15 minutes	15	24.00	9.00	**3240.00**	
Psychology	☐	15 minutes	15	24.00	31.25	**11250.00**	
Speech Therapy	☐	15 minutes	15	24.00	11.25	**4050.00**	
Occupational Therapy	☐	15 minutes	15	24.00	12.00	**4320.00**	
Transportation-Community Access Total:							**15600.00**
Transportation-Community Access	☐	Per Service	15	52.00	20.00	**15600.00**	

GRAND TOTAL:	**80154740.74**
Total: Services included in capitation:	2932813.37
Total: Services not included in capitation:	77221927.37
Total Estimated Unduplicated Participants:	**2200**
Factor D (Divide total by number of participants):	**36433.97**
Services included in capitation:	1333.10
Services not included in capitation:	35100.88
Average Length of Stay on the Waiver:	311

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							**602349.28**
Adult Day Health Care	☐	15 minutes	52	3967.00	2.92	**602349.28**	
Day Habilitation Total:							**1023045.76**
Day Habilitation	☐	15 Minutes	158	2287.00	2.56	**925045.76**	
Transportation	☐	Per Diem	50	98.00	20.00	**98000.00**	
Monitored In Home Caregiving Total:							**2003951.20**
Monitored In Home Caregiving-Level 2	☐	Per Diem	5	310.00	135.04	**209312.00**	
Monitored In Home Caregiving- intake and assessment	☐	One Time	6	1.00	250.00	**1500.00**	
Monitored In Home Caregiving-Level 1	☐	Per Diem	64	310.00	90.38	**1793139.20**	
Prevocational Services Total:							**51176.72**
Transportation	☐	Per Diem	2	98.00	20.00	**3920.00**	
Prevocational Habilitation	☐	15 minutes	7	2446.00	2.76	**47256.72**	
Respite Services - Out of Home Total:							**60831.18**
Respite Services - Out of Home	☐	15 minutes	9	2042.00	3.31	**60831.18**	
Shared Living Services Total:							**2141100.00**
Shared Living Services	☐	Per Diem	120	305.00	58.50	**2141100.00**	
Support Coordination Total:							**4174011.90**
Support Coordination	☐	Monthly	2361	10.00	176.79	**4174011.90**	
Supported Employment Total:							**1027478.70**
Transportation	☐	Per Diem	29	172.00	20.00	**99760.00**	
Supported Employment	☐	15 minutes	113	2755.00	2.98	**927718.70**	
Assistive Technology/Specialized Medical Equipment and Supplies Total:							**1848.00**
Assistive	☐					**1848.00**	

GRAND TOTAL:	**89083244.56**
Total: Services included in capitation:	3295837.48
Total: Services not included in capitation:	85787407.08
Total Estimated Unduplicated Participants:	**2400**
Factor D (Divide total by number of participants):	**37118.02**
Services included in capitation:	1373.27
Services not included in capitation:	35744.75
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Technology/Specialized Medical Equipment and Supplies		Per Service	4	2.00	231.00		
Financial Management Services Total:							**369779.12**
Financial Management Services	☐	Monthly	333	10.78	103.01	**369779.12**	
Community Life Engagement Development Total:							**1227518.60**
Community Life Engagement Development	☐	15 minute	154	1930.00	4.13	**1227518.60**	
Community Living Supports Total:							**60334848.00**
Community Living Supports	☐	15 minutes	1680	9280.00	3.87	**60334848.00**	
Companion Care Total:							**12091428.00**
Companion Care	☐	Per Diem	360	365.00	92.02	**12091428.00**	
Dental Services Total:							**3295837.48**
Dental Services	☒	Monthly	2361	10.22	136.59	**3295837.48**	
Environmental Accessibility Adaptations Total:							**199010.40**
Environmental Accessibility Adaptations	☐	Per Service	16	3.00	4146.05	**199010.40**	
Host Home Total:							**13188.00**
Host Home	☐	Per Diem	240	1.00	54.95	**13188.00**	
Housing Stabilization Service Total:							**1873.64**
Housing Stabilization Service	☐	15 minutes	4	31.00	15.11	**1873.64**	
Housing Stabilization Transition Service Total:							**3747.28**
Housing Stabilization Transition Service	☐	15 minutes	4	62.00	15.11	**3747.28**	
Nursing Total:							**284101.30**
Nursing	☐	15 Minutes	14	521.00	38.95	**284101.30**	
One-Time Transitional Services Total:							**90000.00**
One-Time Transitional Services	☐					**90000.00**	

GRAND TOTAL:	**89083244.56**
Total: Services included in capitation:	3295837.48
Total: Services not included in capitation:	85787407.08
Total Estimated Unduplicated Participants:	**2400**
Factor D (Divide total by number of participants):	**37118.02**
Services included in capitation:	1373.27
Services not included in capitation:	35744.75
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		Per Service	30	1.00	3000.00		
Personal Emergency Response System Total:							**36936.00**
Personal Emergency Response System	☐	Monthly	152	9.00	27.00	**36936.00**	
Professional Services Total:							**32544.00**
Physical Therapy	☐	15 minutes	16	24.00	13.75	**5280.00**	
Licensed Clinical Social Work	☐	15 minutes	16	24.00	7.50	**2880.00**	
Registered Dietician	☐	15 minutes	16	24.00	9.00	**3456.00**	
Psychology	☐	15 minutes	16	24.00	31.25	**12000.00**	
Speech Therapy	☐	15 minutes	16	24.00	11.25	**4320.00**	
Occupational Therapy	☐	15 minutes	16	24.00	12.00	**4608.00**	
Transportation-Community Access Total:							**16640.00**
Transportation-Community Access	☐	Per Service	16	52.00	20.00	**16640.00**	

GRAND TOTAL:	**89083244.56**
Total: Services included in capitation:	3295837.48
Total: Services not included in capitation:	85787407.08
Total Estimated Unduplicated Participants:	**2400**
Factor D (Divide total by number of participants):	**37118.02**
Services included in capitation:	1373.27
Services not included in capitation:	35744.75
Average Length of Stay on the Waiver:	311

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							**648683.84**
Adult Day Health Care	☐	15 minutes	56	3967.00	2.92	**648683.84**	
Day Habilitation Total:							**1110917.12**
Day Habilitation	☐	15 Minutes	171	2287.00	2.56	**1001157.12**	
Transportation	☐	Per Diem	56	98.00	20.00	**109760.00**	
Monitored In Home Caregiving Total:							**2164713.00**
Monitored In Home Caregiving-Level 2	☐	Per Diem	5	310.00	135.04	**209312.00**	
Monitored In Home Caregiving- intake and assessment	☐	One time	7	1.00	250.00	**1750.00**	
Monitored In Home Caregiving-Level 1	☐	Per Diem	70	310.00	90.03	**1953651.00**	
Prevocational Services Total:							**57927.68**
Transportation	☐	Per Diem	2	98.00	20.00	**3920.00**	
Prevocational Habilitation	☐	15 minutes	8	2446.00	2.76	**54007.68**	
Respite Services - Out of Home Total:							**67590.20**
Respite Services - Out of Home	☐	15 minutes	10	2042.00	3.31	**67590.20**	
Shared Living Services Total:							**2319525.00**
Shared Living Services	☐	Per Diem	130	305.00	58.50	**2319525.00**	
Support Coordination Total:							**4520520.30**
Support Coordination	☐	Monthly	2557	10.00	176.79	**4520520.30**	
Supported Employment Total:							**1115127.80**
Transportation	☐	Per Diem	33	172.00	20.00	**113520.00**	
Supported Employment	☐	15 minutes	122	2755.00	2.98	**1001607.80**	
Assistive Technology/Specialized Medical Equipment and Supplies Total:							**1848.00**
Assistive	☐					**1848.00**	

GRAND TOTAL:	**98313607.62**
Total: Services included in capitation:	3676587.05
Total: Services not included in capitation:	94637020.57
Total Estimated Unduplicated Participants:	**2600**
Factor D (Divide total by number of participants):	**37812.93**
Services included in capitation:	1414.07
Services not included in capitation:	36398.85
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Technology/Specialized Medical Equipment and Supplies		Per Service	4	2.00	231.00		
Financial Management Services Total:							**400871.66**
Financial Management Services	☐	Monthly	361	10.78	103.01	**400871.66**	
Community Life Engagement Development Total:							**1331140.30**
Community Life Engagement Development	☐	15 minute	167	1930.00	4.13	**1331140.30**	
Community Living Supports Total:							**67051712.00**
Community Living Supports	☐	15 minutes	1820	9280.00	3.97	**67051712.00**	
Companion Care Total:							**13099047.00**
Companion Care	☐	Per Diem	390	365.00	92.02	**13099047.00**	
Dental Services Total:							**3676587.05**
Dental Services	☒	Monthly	2557	10.22	140.69	**3676587.05**	
Environmental Accessibility Adaptations Total:							**211448.55**
Environmental Accessibility Adaptations	☐	Per Service	17	3.00	4146.05	**211448.55**	
Host Home Total:							**14287.00**
Host Home	☐	Per Diem	260	1.00	54.95	**14287.00**	
Housing Stabilization Service Total:							**1873.64**
Housing Stabilization Service	☐	15 minutes	4	31.00	15.11	**1873.64**	
Housing Stabilization Transition Service Total:							**3747.28**
Housing Stabilization Transition Service	☐	15 minutes	4	62.00	15.11	**3747.28**	
Nursing Total:							**324687.20**
Nursing	☐	15 minutes	16	521.00	38.95	**324687.20**	
One-Time Transitional Services Total:							**99000.00**
One-Time Transitional Services	☐					**99000.00**	

GRAND TOTAL:	**98313607.62**
Total: Services included in capitation:	3676587.05
Total: Services not included in capitation:	94637020.57
Total Estimated Unduplicated Participants:	**2600**
Factor D (Divide total by number of participants):	**37812.93**
Services included in capitation:	1414.07
Services not included in capitation:	36398.85
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		Per Service	33	1.00	3000.00		
Personal Emergency Response System Total:							**40095.00**
Personal Emergency Response System	☐	Monthly	165	9.00	27.00	**40095.00**	
Professional Services Total:							**34578.00**
Physical Therapy	☐	15 minutes	17	24.00	13.75	**5610.00**	
Licensed Clinical Social Work	☐	15 minutes	17	24.00	7.50	**3060.00**	
Registered Dietician	☐	15 minutes	17	24.00	9.00	**3672.00**	
Psychology	☐	15 minutes	17	24.00	31.25	**12750.00**	
Speech Therapy	☐	15 minutes	17	24.00	11.25	**4590.00**	
Occupational Therapy	☐	15 minutes	17	24.00	12.00	**4896.00**	
Transportation-Community Access Total:							**17680.00**
Transportation-Community Access	☐	Per Service	17	52.00	20.00	**17680.00**	

GRAND TOTAL:	**98313607.62**
Total: Services included in capitation:	3676587.05
Total: Services not included in capitation:	94637020.57
Total Estimated Unduplicated Participants:	**2600**
Factor D (Divide total by number of participants):	**37812.93**
Services included in capitation:	1414.07
Services not included in capitation:	36398.85
Average Length of Stay on the Waiver:	311

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:							**706602.04**
Adult Day Health Care	☐	15 minutes	61	3967.00	2.92	**706602.04**	
Day Habilitation Total:							**1196828.48**
Day Habilitation	☐	15 Minutes	184	2287.00	2.56	**1077268.48**	
Transportation	☐	Per Diem	61	98.00	20.00	**119560.00**	
Monitored In Home Caregiving Total:							**2360328.10**
Monitored In Home Caregiving-Level 2	☐	Per Diem	5	310.00	135.04	**209312.00**	
Monitored In Home Caregiving- intake and assessment	☐	One time	8	1.00	250.00	**2000.00**	
Monitored In Home Caregiving-Level 1	☐	Per Diem	77	310.00	90.03	**2149016.10**	
Prevocational Services Total:							**57927.68**
Transportation	☐	Per Diem	2	98.00	20.00	**3920.00**	
Prevocational Habilitation	☐	15 minutes	8	2446.00	2.76	**54007.68**	
Respite Services - Out of Home Total:							**67590.20**
Respite Services - Out of Home	☐	15 minutes	10	2042.00	3.31	**67590.20**	
Shared Living Services Total:							**2497950.00**
Shared Living Services	☐	Per Diem	140	305.00	58.50	**2497950.00**	
Support Coordination Total:							**4868796.60**
Support Coordination	☐	Monthly	2754	10.00	176.79	**4868796.60**	
Supported Employment Total:							**1207546.80**
Transportation	☐	Per Diem	36	172.00	20.00	**123840.00**	
Supported Employment	☐	15 minutes	132	2755.00	2.98	**1083706.80**	
Assistive Technology/Specialized Medical Equipment and Supplies Total:							**1848.00**
Assistive	☐					**1848.00**	

GRAND TOTAL:	**107675929.48**
Total: Services included in capitation:	4078619.47
Total: Services not included in capitation:	103597310.01
Total Estimated Unduplicated Participants:	**2800**
Factor D (Divide total by number of participants):	**38455.69**
Services included in capitation:	1456.65
Services not included in capitation:	36999.04
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Technology/Specialized Medical Equipment and Supplies		Per Service	4	2.00	231.00		
Financial Management Services Total:							**431964.19**
Financial Management Services	☐	Monthly	389	10.78	103.01	**431964.19**	
Community Life Engagement Development Total:							**1434762.00**
Community Life Engagement Development	☐	15 minute	180	1930.00	4.13	**1434762.00**	
Community Living Supports Total:							**73846528.00**
Community Living Supports	☐	15 minutes	1960	9280.00	4.06	**73846528.00**	
Companion Care Total:							**14106666.00**
Companion Care	☐	Per Diem	420	365.00	92.02	**14106666.00**	
Dental Services Total:							**4078619.47**
Dental Services	☒	Monthly	2754	10.22	144.91	**4078619.47**	
Environmental Accessibility Adaptations Total:							**236324.85**
Environmental Accessibility Adaptations	☐	Per Service	19	3.00	4146.05	**236324.85**	
Host Home Total:							**15386.00**
Host Home	☐	Per Diem	280	1.00	54.95	**15386.00**	
Housing Stabilization Service Total:							**1873.64**
Housing Stabilization Service	☐	15 minutes	4	31.00	15.11	**1873.64**	
Housing Stabilization Transition Service Total:							**3747.28**
Housing Stabilization Transition Service	☐	15 minutes	4	62.00	15.11	**3747.28**	
Nursing Total:							**344980.15**
Nursing	☐	15 minutes	17	521.00	38.95	**344980.15**	
One-Time Transitional Services Total:							**108000.00**
One-Time Transitional Services	☐					**108000.00**	

GRAND TOTAL:	**107675929.48**
Total: Services included in capitation:	4078619.47
Total: Services not included in capitation:	103597310.01
Total Estimated Unduplicated Participants:	**2800**
Factor D (Divide total by number of participants):	**38455.69**
Services included in capitation:	1456.65
Services not included in capitation:	36999.04
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		Per Service	36	1.00	3000.00		
Personal Emergency Response System Total:							**43254.00**
Personal Emergency Response System	☐	Monthly	178	9.00	27.00	**43254.00**	
Professional Services Total:							**38646.00**
Physical Therapy	☐	15 minutes	19	24.00	13.75	**6270.00**	
Licensed Clinical Social Work	☐	15 minutes	19	24.00	7.50	**3420.00**	
Registered Dietician	☐	15 minutes	19	24.00	9.00	**4104.00**	
Psychology	☐	15 minutes	19	24.00	31.25	**14250.00**	
Speech Therapy	☐	15 minutes	19	24.00	11.25	**5130.00**	
Occupational Therapy	☐	15 minutes	19	24.00	12.00	**5472.00**	
Transportation-Community Access Total:							**19760.00**
Transportation-Community Access	☐	Per Service	19	52.00	20.00	**19760.00**	

GRAND TOTAL:	**107675929.48**
Total: Services included in capitation:	4078619.47
Total: Services not included in capitation:	103597310.01
Total Estimated Unduplicated Participants:	**2800**
Factor D (Divide total by number of participants):	**38455.69**
Services included in capitation:	1456.65
Services not included in capitation:	36999.04
Average Length of Stay on the Waiver:	311