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					
	☐	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:

To decrease the number of eligible individuals institutionalized in the state by boarding capacity in the ROW to serve eligible individuals the following populations and based on the following priorities:

Priority 1. The one-time transition of persons eligible for Developmental Disability (DD)services in either OAAS Community Choices Wavier (CCW)or OAAS Adult Day Health Care Waiver(ADHC) to the ROW.

Priority 2. Adults and children residing in institutions [nursing facilities and private Intermediate Care Facilities for the Intellectually & Developmentally Disabled (ICF/IDDs, Supports & Services Center or former Supports & Services Center operated through a Cooperative Endeavor Agreement (CEA) with OCDD)] who are eligible for Developmental Disability (DD) services and who wish to transition to the ROW

Priority 3. Adults and children in crisis situations who are eligible for DD services and who need HCBS services to prevent Institutionalization.

Priority 4. Persons who are eligible for DD services and who request the ROW, based on their ROW Request for Services Registry (RFSR) protected date and a first come first serve basis.

Once an eligible individual is identified, the case management agency will conduct person centered discovery

activities and two needs-based assessments. The Louisiana Plus assessment will be conducted for all individuals, and the Supports Intensity Scale assessment for adults only (21 and older). ROW opportunities will be offered to individuals based on the results of the LA Plus or the Supports Intensity Scale and the person centered planning discussion. The plan of care, with the needs-based assessments will be validated by the LGE through the required in-home visit for all initial waiver recipients. Individuals who disagree with the OCDD waiver offered as a result of the needs-based assessments and person centered planning process may appeal the waiver offer decision through the OCDD appeals process.

Funded waiver opportunities will only be allocated to individuals who successfully complete the financial eligibility and medical certification eligibility process required for waiver certification. The Office for Citizens with Developmental Disabilities has the responsibility to monitor the utilization of ROW waiver opportunities. At the discretion of the OCDD Assistant Secretary, specifically allocated waiver opportunities may be reallocated to better meet the needs of citizens with developmental disabilities in the State of Louisiana.

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

◉ **Other:**

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

•

• The LGEs 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 LGEs or Support Coordinator Supervisor. • Each residential and vocational provider must document completion of their own service plans which mirror the Plan of Care and outlines specifics on how services will be delivered in their settings. The support coordinator is responsible for reviewing and assuring that these plans correctly implement the objectives within the approved Plan of Care. 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 LGEs 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 - Health and Hospitals Section regarding the following determinations:

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

•During the initial assessment process, the Support Coordinator will give a participant and his/her legal representatives an OCDD information sheet entitled "Rights and Responsibilities for Applicants/Participants of a

Home and Community Based Waiver" which includes information on how to file a complaint, grievance, or appeal with the Louisiana Department of Health. 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 - Health and Hospitals Section in writing, by phone or e-mail. The LGEs are responsible for giving information to the individual and his/her legal representatives of how to contact the Division of Administrative Law - Health and Hospitals Section by writing, phone or e-mail, and how to contact the Advocacy Center by phone or mail. This is done at the time of enrollment and at any other time the participant and his/her legal representative requests the number(s).

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

In accordance with 42CFR 431.206, 210 and 211, participants receiving waiver services, and their legal representatives are sent a certified letter with return receipt to ensure the participant receives it by the appropriate 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 - Health and Hospitals Section no later than seven calendar days after receipt. A copy of the letter and the response/request is kept in the participant's record at the appropriate LGE.

Anyone requesting an appeal has the right to withdraw the appeal request at any time prior to the hearing. The appellant may contact the Division of Administrative Law - Health and Hospitals Section directly, or may request withdrawal through the 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 fifteen days prior to the transfer or discharge from the provider agency with the proposed date of the transfer/discharge, the reason for the action, and the names of personnel available to assist the participant throughout the process. The enrolled provider of waiver services must also provide the participant and his/her legal representatives with information on how to request an appeal of a decision for involuntary discharge. A copy of the notice of intent to transfer/discharge, and information that was provided on how to access the appeal process is kept in the participant's record at the enrolled provider of waiver services' physical location of business.

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

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

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

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

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

☑ **Other safeguard(s)**

Specify:

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

A reassessment of the participant's ICAP level will be conducted to determine the most appropriate support level. If it is determined that the ROW can no longer meet the participant's health and safety and support the participant, the case management agency will conduct person centered discovery activities and two needs-based assessments.

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

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	625
Year 2	725
Year 3	825
Year 4	925
Year 5	1025

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	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
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:

The rule for the ROW published in the Louisiana Register, Volume 37 No. 12, December 20, 2011 specifies the groups identified for selection into this waiver.

The following categories of individuals from the ID/DD target group will be awarded ROW opportunities:

- Persons who meet the ICF/DD level of care and who need HCBS due to a health and/or safety crises situation (crisis diversion)

- Children (including birth through age 18) in NFs requiring high-need rates who wish to transition to HCBS residential services and who meet the level of care that qualifies them for ROW eligibility who participate in the MFP
- Adults and children in Nursing Facilities (NFs) who wish to transition to HCBS residential services and who meet the level of care (LOC) that qualifies them for ROW eligibility based on their Request for Services Registry (RFSR) protected date
- Persons residing in ICFs/DD who wish to transition to a HCBS residential service setting through a voluntary conversion opportunity
- Persons residing in ICFs/DD who wish to transition to a HCBS residential service setting and are eligible based on their Request for Services Registry (RFSR) protected date
- Persons transitioning from Supports and Services Centers into home and community based services

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

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.

BHSF/MPSW and OCDD reviews slot allocation data to determine if there is any under-utilization or anticipated over-utilization in the waiver slots reserved for priority groups. During this process, stakeholder input is utilized to make policy revisions to ensure the equitable and fair allocation of waiver slots. In addition, public input is solicited during the State's rulemaking process (as enacted through R.S. 49:951 et seq. Act No. 775 §1, effective June 30, 2010 of the 2010 Regular Legislative Session). BHSF/MPSW will submit an amendment to the waiver, as necessary, to denote changes to the waiver slot allocations.

Medicaid's data contractor has responsibility for maintenance of the Request for Services Registry (RFSR) and for slot offers according to policy as written in B-3-f. BHSF/MPSW has oversight of the data contractor's role in maintaining the registry according to that policy. In addition, bi-weekly meetings are held between the Medicaid data contractor, OCDD, and BHSF/MPSW to review and to assure adherence to these regulations along with equitability and fairness in slot allocations and distributions.

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**
- ☑ **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 spenddown 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 five-year period beginning January 1, 2014, 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 December 31, 2018.*

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (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. 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 (see instructions)**
○ **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).

Answers provided in Appendix B-5-a 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 (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.

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 (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).

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-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 an entity 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:

The Level of Care evaluation and re-evaluation is completed by a Medical Certification Specialist 1 or 2 and/or a Health Standards Certification Specialist 1 or 2.

The basic qualifications for the Health Standards Certification Specialist 1 (HSCS-1) are as follows:

A baccalaureate degree plus three years of professional level experience in hospital or nursing home administration, public health administration, social services, nursing, pharmacy, dietetics/nutrition, physical therapy, occupational therapy, or medical technology or in related professions in the health and social care industries. Eight years of full-time work experience in any field may be substituted for the required baccalaureate degree.

The HSCS-2 must be followed by one additional year of professional experience in the qualifying fields, or surveying health or social service programs or facilities for compliance with state and federal regulations.

The basic qualifications of the Medical Certification Specialist 1 (MCS-1) are as follows:
A baccalaureate degree plus three years of professional level experience in nursing, pharmacy, dietetics/nutrition, physical therapy, occupational therapy, or medical technology, or surveying 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 MCS-2 must be followed by four years of professional level experience, rather than the three years of professional experience.

All activities are supervised by individuals with education, experience, and training in the diagnosis of ID/DD.

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 person's 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 Medicaid Bureau of Health Services Financing (BHSF) form 90-L is used to determine the ICF/DD Level of Care. The individual's primary care 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/DD 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 OCDD LGE or Human Services Authorities or Districts that 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 ROW Request for Services Registry for waiver services and their protected date of request. The 90-L, SOA and plan of care documents are submitted by the Support Coordination Agency to the OCDD Regional Waiver Supports and Services Offices or Human Services Authorities or Districts 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 Local Governing Entity (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 Local Governing Entity (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 or 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/DD level of care. The 90-L is used in conjunction with the Statement of Approval to establish a level of care criteria and to complete the Plan of Care. The 90-L, Statement of Approval and Plan of Care documents are submitted to the LGE for staff review to assure that the applicant/participant meets/continues to meet the level of care criteria. The LGE staff conducts a pre-certification home visit to verify accuracy of level of care for all initial evaluations.

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. Level of Care evaluations are conducted at least annually.

The Developmental Disability decision is made by the OCDD Local Governing Entity (LGE) utilizing the systems entry process. If the individual is determined to meet the DD criteria they are issued a Statement of Approval, 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. 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 case management services, or
2. Bachelor or master's degree in nursing (RN) (one year of experience will substitute for the degree) and two years of paid post degree experience in providing case management services, 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 case management services.
4. 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 case management 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 Support Coordination Supervisor/LGE sends an approved Plan of Care to the Medicaid data contractor, the information contains the date of the 90L (date of the physician'/designee (nurse practitioner or physician's assistant who practices under the supervision and license of the physician) signature.) This date is tracked in the data contractor's database for every Plan of Care. The 90L date is compared to the Plan of Care begin date to determine if the reevaluation was performed timely. The database generates a report which is shared with both LGE 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 LGEs 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 State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: 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/DD 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.1. Number and percentage of initial applicants who's LOC has been completed following state procedures. Percentage = Number of initial applicants with a current SOA and current 90-L/Total number of initial LOC's 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**

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:
B.a.i.c.2 Number and percentage of initial waiver applicant's 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**
☐ **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 the LGE 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 State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Performance Measures 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 OCDD currently utilizes the "Case Management Choice and Release of Information Form" to provide a means for the person to state that they understand their choice between institutional and HCBS and the alternatives under the waiver. The information is also reviewed with the participant and/or authorized representative at a pre-certification home visit conducted by the LGE staff prior to approval of the initial Plan of Care. The Support Coordinator offers the choice between institutional and HCBS, 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):
A language service vendor, Certified Languages International, under contract with DHH, the single state Medicaid Agency. All forms are published in English, Spanish, and Vietnamese and are available in alternative format upon request.

CLI is available to assist with all enrollee communication needs related to Medicaid eligibility, the entry process & getting someone approved for services. Service delivery communication is the responsibility of the service provider.

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	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
Extended State Plan Service	Dental
Other Service	Community Living Supports
Other Service	Companion Care
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:**

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

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

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

Service Definition *(Scope):*
Services 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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care Center

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 Care Center
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:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

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

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

Service Definition *(Scope):*
Day Habilitation Services are aimed at developing activities and/or skills acquisition to support or further community integration opportunities outside of participant's home that promote independence, autonomy and assist him/her in developing a full life in his/her community. Services should focus on habilitation activities that enable the participant to attain maximum skills based on his/her valued outcomes. These services should be provided in a variety of community venues and these venues should routinely correspond with the context of the skill acquisition activity to enhance the habilitation activities. Overarching goals of the program shall include regular community inclusion and the opportunity to build towards maximum independent status for the participant.

The primary focus of Day Habilitation Services is the acquisition of new skills or maintenance of existing skills based on personalized preferences and goals. The skill acquisition/maintenance activities should include formal strategies for teaching the personalized skills and include the intended outcome for the participant. Personalized progress for the skill acquisition/maintenance activities should be routinely reviewed and evaluated with revisions made as necessary to promote continued skill acquisition. As a participant develops new skills, his/her training should move along a continuum of habilitation services offered toward greater independence and self-reliance.

Day Habilitation Services shall focus on enabling the participant to attain his/her maximum skills and shall be coordinated with any physical, occupational, or speech therapies listed in the participant's Plan of Care. In addition Day Habilitation Services may serve to reinforce skills or lessons taught in school, therapy, or other settings.
Services shall be furnished on a regularly scheduled basis, for one or more days per week based on a 2.5 hour unit of service. The 2.5 hour unit of service must be spent at the service site by the participant. Two units may be billed if the participant spends a minimum of 5 hours at the service site. Any time less than 2.5 hours of service is not billable or payable. No rounding up of hours, such as 4.5 equals 5 is allowed.

Transportation is provided as a component part of day habilitation services and the cost of this transportation is included in the rate paid to providers of day habilitation services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
- The Day Habilitation provider is responsible for all transportation between day habilitation sites.
- Transportation is only provided on the day a day habilitation service is provided.
- Time spent in transportation between the participant's 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 participant's Plan of Care.
- Cannot be billed for at the same time on the same day as Community Living Supports, Respite-Out of Home, Prevocational Services, or Supported Employment.
- 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 and Hospitals 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:
Department of Health and Hospitals (Health Standards Section)
Frequency of Verification:
Initially, annually and as necesary

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Prevocational Services
Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
Prevocational Services are prevocational activities designed to assist a participant in acquiring and maintaining basic work-related skills necessary to acquire and retain competitive employment. Overall goals of the program include regular community inclusion and development of work skills and habits to improve the employability of the participant.
Services should be offered which engage workers in real and simulated employment tasks to determine vocational potential. Services focus on teaching concepts and skills such as following directions, attending to task, task completion, problem solving, and job safety skills. All Prevocational Services are to be reflective of the participant's Plan of Care and directed toward habilitation rather than teaching a specific job skill.
The primary focus of Prevocational Services is the acquisition of employment related skills based on the participant's vocational preferences and goals. These activities should include formal strategies for teaching the skills and the intended outcome for the participant. Personalized progress for the activities should be routinely reviewed and evaluated with revisions made as necessary.
Prevocational Services are provided to participants who are working or will be able to work in a paid work setting. Participants need intensive ongoing support to perform in a paid work setting because of their disabilities. In the event participants are compensated in the prevocational services, pay must be in accordance with the United States Fair Labor Standards Act of 1985. If participants are paid in excess of 50% of minimum wage the provider must conduct at a minimum: 6 month formal reviews to determine the suitability of this service rather than Supported Employment services; recommendations to transition the participant to a more appropriate vocational opportunity; and provide the support coordinator with documentation of both the productivity time studies and documented reviews of current placement feasibility.
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 (16) and (17) of the Individuals with Disabilities Education Act, 20 U.S.C. 1401 (16) and (71).
Services shall be furnished on a regularly scheduled basis, for one or more days per week based on a 2.5 hour unit of service. The 2.5 hour unit of service must be spent at the service site by the participant. Two units may be billed if the participant spends a minimum of 5 hours at the service site. Any time less than 2.5 hours of service is not billable or payable. No rounding up of hours, such as 4.5 equals 5, is allowed.

Transportation may be provided between the participat's residence (or other location as agreed upon by the participant or authoirzed representative) and the prevocational dite. Transportation is provided as a componenet part of prevocational servcies and the cost of this transportation is included in the rate paid to providers of prevocational services.

Individual goals are identified and included in the participant's Plan of Care.
These goals are re-assessed at least quarterly, more often as needed and revised as necessary.

As an Employment 1st state, the State's strategy to facilitate participant transition from prevocational services to supported employment and/or employment in the participant's occupation of choice includes individually identifying persons receiving prevocational services and targets them for transition to integrated employment

opportunities. This is accomplished through a revised person–centered process prominently featuring the values and principles of the state's Employment1st Initiative. As part of this implementation, the support team must clearly identify integrated community-based vocational goals, action steps and timelines. This is reviewed on at least a quarterly basis and revised as needed. Success is measured by the individual's transition to an integrated employment setting in addition to the state meeting National Core Indicator integrated employment targets.

Individual goals are identified and included in the participant's Plan of Care. Support Coordinators are to monitor and ensure that meaningful activities are occurring and that the participant is not being exploited. Support Coordinators are to re-assess goals at least quarterly, more often as needed and revise as appropriate. Support coordinators are required to visit the participant at the prevocational site to ensure the participant is participating in meaningful activities, are satisfied with services, and free from abuse/neglect. This is documented in the Case Management Information System.

During the person-centered planning process, support coordinators identify various types of activities the participant enjoys participating in or would like to participant in given personal preferences and goals. These activities are included in the participants Plan of Care and monitored to ensure that the participant has the opportunity to participate.

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

•Services shall be limited to no ore than 8 hours a day, 5 days a week.

The Prevocational provider is responsible for all transportation between Prevocational sites.

- Transportation is only provided on the day a Prevocational service is provided.
- Time spent in transportation between the participant's residence/location and the Prevocational site is not to be included in the total number of Prevocational services hours per day, except when the transportation is for the purpose of travel training. Travel training must be included in the participant's Plan of Care.
- Cannot be billed for at the same time on the same day as Community Living Supports, Respite-Out of Home, Day Habilitation Services, or Supported Employment.
- 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.

- If a participant is compensated, compensation must be less than 50% of minimum wage and must be in accordance with the United States Department of Labor's Fair Labor Standards Act. If a participant is paid above 50% of minimum wage, there must be a review every six months to determine the suitability of continuing Prevocational services or changing vocational services to Supported Employment.

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

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 and Hospitals 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:
Department of Health and Hospitals (Health Standards Section)

Frequency of Verification:
Initially, annually, and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
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:**

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

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

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

Service Definition *(Scope):*
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 is 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:
- 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 and Hospitals 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:
Department of Health and Hospitals (Health Standards Section)

Frequency of Verification:
Initially, annually and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
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:**

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

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

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

Service Definition *(Scope):*
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 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:
  - o Units have lockable entrance doors, with appropriate staff having keys to doors;

o Participants share units only at the participant's choice; and
o 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 may be shared by up to six participants and who have a common Shared Living provider agency.
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/DD providers who convert an ICF/DD to an SIL 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/DD 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/DD prior to beginning the process of conversion.

ICF/DD providers who elects to convert to an SIL via the shared living conversion process shall submit a licensing application for a HCBS provider license, SIL 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)

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

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Case Management
Alternate Service Title (if any):
Support Coordination

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
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 DHH 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 DHH 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:

- Bachelor or Master Degree in social work from a program accredited by the Council on Social Work Education; or
- Bachelors or Master Degree in nursing (RN)currently licensed in Louisiana (one year of paid experience will substitute for the degree); or
- Bachelor or Master Degree in a human service field which includes; psychology, education, counseling, social services, sociology, philosophy, family and consumer sciences, criminal justice, rehab services, child development, substance abuse, gerontology, and vocational rehabilitation; or
- 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.

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

Orientation and Training for New Employees

New Staff Orientation
- Orientation of at least sixteen (16) hours must be provided to all staff, volunteers, and students within five (5) working days of employment
- A minimum of eight (8) hours of the orientation training must cover orientation to the target population including, but not limited to, specific service needs and resources

This orientation must include, at a minimum the following:
- 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 forty (40) 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 forty (40) hour minimum annual training requirement. Appropriate updates of topics covered in orientation and training for a new case manager must be included in the required forty (40) hours of annual training.

The following is a list of suggested additional topics for training:

- 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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
Supported Employment is competitive work 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 served by Louisiana Rehabilitation Services or through a local education agency under IDEA and who need more intense, long term follow along and usually cannot be competitively employed because supports cannot be successfully faded. Some examples of Supported Employment are:

1. Individual placement: A supported employment placement strategy in which an employment specialist (job coach) assists a person locating competitive employment, providing training and supporting, then gradually reducing time and assistance at the worksite.
2. Services that assist a participant to develop and operate a 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.
3. Enclave: An employment situation in competitive employment in which a group of eight or fewer workers with disabilities are working at a particular work setting performing similar general job tasks. The disabled workers may be disbursed throughout the company and among non-disabled workers or congregated as a group in one part of the business.
4. Mobile Work Crew: A group of eight or fewer workers with disabilities who perform work in a variety of locations under the supervision of a permanent employment specialist (job coach/supervisor).

The required minimum number of service hours per day per participant are as follows:
1) Individual placement - 1 hour;
2)Services that assist a participant to develop and operate a micro-enterprise - 1 hour;
3)Enclave -2.5 hours; and 4) Mobile Work Crew - 2.5 hours.
Any time less than the mimimum number of hours of service specified above for any model is not billable or payable.

The units of service for models numbered 1 and 2 above are one hour spent on the job site or training with the job coach per participant per day.

The units of service for models 3 and 4 above are a minimum of 2.5 hours spent at the job site per participant per day. Two half-day units may be billed if the participant spends a minimum of 5 hours spent at the service site. No rounding up of hours, such as 4.5 equals 5 hours is allowed.
FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the

following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

Supported Employment Services may be delivered either by an Adult Day Center or a Community Rehabilitation Program provider.

The state intends to strategically move from segregated employment toward individual employment with a significant increase individual employment being a long-term goal. The general strategy for transitioning current waiver participants into integrated employment activities includes training and education (participants, family, support coordinators, providers, etc.). The participant's planning process will be person-centered and focus on employment activities the participant wishes to pursue. This will take into account, personal interests and abilities and identify any supports that the participant may need to be successfully employed
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Cannot be billed for the same time as any of the following services:
Community Living Supports
Professional Services (except those direct contacts needed to develop a behavioral management plan) Respite Services - Out of Home.

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 work sites related to the provision of services. Transportation to and from the service site is offered and billable as a component of the Supported Employment Service.

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	Adult Day Center

Provider Category	Provider Type Title
Agency	Community Rehabilitation Program

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

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

Certificate *(specify):*
Louisiana Rehabilitation Services Compliance Certificate
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Louisiana Rehabilitation Services
Frequency of Verification:

Initially, annually, and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

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:**

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

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

Service Definition *(Scope):*

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.

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.

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 manufacturer's 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 (Current Contractor is Molina)

Frequency of Verification:
Initially, annually and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service

Service Title:
Dental

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*
ROW Dental services include adult diagnostic, preventative, prophylaxis new and patient of record.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
ROW Dental services are not available to children (up to 21 years of age). Children access dental services through EPSDT.

All available Medicaid State Plan services must first be exhausted prior to accessing ROW Dental 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	Dentist-Individual or Group

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Dental

Provider Category:
Agency

Provider Type:
Dentist-Individual or Group

Provider Qualifications

License *(specify)*:
Dentistry License
LA RS 37:751, 37:753

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana State Board of Dentistry

Frequency of Verification:
Initially and every 2 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:
Community Living Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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

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

Service Definition *(Scope):*
Community 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 in level of independence, autonomy, and adaptive skills. This includes self-help skills, socialization skills, cognitive skills, 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 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 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.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Payment will not be made for services provided by a relative who is:

- 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 routine care and support that is normally provided by the participant's family or

for services furnished to a minor by the child's parent or step-parent or by a participant's spouse.

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

The participant and Community Living Supports staff may not live in the same place of residence.

Payment does not include room and board or 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 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

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
Individual	Direct Support Worker
Agency	Personal Care Attendant

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;
- Provide documentation of current Cardiopulmonary Resuscitation and First Aid Certifications.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal/employer agent (Current contractor is Acumen)

Frequency of Verification:

Initially, annually and as needed.

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

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 and Hospitals 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:
Department of Health and Hospitals (Health Standards Section)

Frequency of Verification:
Initially, annually, and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:
Companion Care

HCBS Taxonomy:

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

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

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

Service Definition *(Scope)*:
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 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 participant's 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 participant's 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 participant's 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 services provided by a relative who is a:
- Parent(s) of a minor child;
- Legal guardian of an adult or child with developmental disabilities;or
- Spouse

Payment will not be made for:
- Community Living Supports
- Shared Living
- Host Home
- Respite Care Services-Out of Home
- Transportation-Community Access

Payment does not include room and board or maintenance, upkeep and improvement of the participant's or provider's 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 and Hospitals 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:
Department of Health and Hospitals (Health Standards Section)

Frequency of Verification:
Initially, annually and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Environmental Accessibility Adaptations

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
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 for a specific approved adaptation;
- May be applied to rental or leased property only with the written approval of the landlord and approval of OCDD Regional Waiver Supports and Services Offices and/or Human Services Authorities or Districts;
- 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 OCDD Regional Waiver Supports and Services Office or Human Services Authority or District.

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 basis 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 by the Louisiana Motor Vehicle Commission as a "Specialty Vehicle Dealer" and accreditation by the National Mobility Equipment Dealers Association under the "Structural Vehicle Modifier"

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:**

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

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

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

Service Definition *(Scope):*
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 int he 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 child's 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:
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

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

Payment does not include room and board or maintenance, upkeep and improvement of the Host Home

Family's residence. Environmental Adaptations are not available to participant's receiving Host Home services since the participant's 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

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:
Class A Child Placing Agency License
Act 286 of 1985, LAC Title 48 Chapter 41

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

Certificate *(specify)*:

Other Standard *(specify)*:
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)

Department of Health and Hospitals (Health Standards Section)

Frequency of Verification:
Initially, annually and as necessary.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:
Housing Stabilization Service

HCBS Taxonomy:

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

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

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

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

1. Conduct a housing assessment identifying the participant's preferences related to housing (type, location, living alone or with someone else, accommodations needed, other important preferences) and needs for support

to maintain housing (including access to, meeting terms of lease, and eviction prevention), budgeting for housing/living expenses, obtaining/accessing sources of income necessary for rent, home management, establishing credit and understanding and meeting obligations of tenancy as defined in lease terms.

2. Assist participant to view and secure housing as needed. This may include arranging or providing transportation. Assist participant to secure supporting documents/records, completing/submitting applications, securing deposits, locate furnishings.

3. Develop an individualized housing stabilization service provider plan based upon the housing assessment that includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies where other provider(s) or services may be required to meet the goal.

4. Participate in the development of the plan of care, incorporating elements of the housing stabilization service provider plan. Participate in plan of care renewal and updates as needed.

5. Provide supports and interventions per the individualized housing stabilization service provider plan. If additional supports or services are identified as needed outside the scope of Housing Stabilization Services, communicate the needs to the Support Coordinator.

6. Communicate with the landlord or property manager regarding the participant's disability, accommodations needed, and components of emergency procedures involving the landlord or property manager.

7. If at any time the participant's housing is placed at risk (eg.,eviction, loss of roommate or income), Housing Stabilization Services will provide supports to retain housing or locate and secure housing to continue community based supports including locating new housing, sources of income, etc.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Available only to participants who:

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

Limited to:

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Permanent Supportive Housing Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Housing Stabilization Service

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

Certificate *(specify)*:

Community Psychiatric and Support Team
Other Standard *(specify):*
Permanent Supportive Housing (PSH) Agency under contract and enrolled with the Department of Health and Hospitals Statewide Management Organization for Behavioral Health Services plus either:

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Housing Stabilization Transition Service enables participants who are transitioning into a PSH unit, including those transitioning from institutions, to secure their own housing. The service is provided while the participant is in an institution and preparing to exit the institution using the waiver. The service includes the following components:

1. Conduct a housing assessment identifying the participant's preferences related to housing (type, location, living alone or with someone else, accommodations needed, other important preferences) and needs for support to maintain housing (including access to, meeting terms of lease, and eviction prevention), budgeting for housing/living expenses, obtaining/accessing sources of income necessary for rent, home management, establishing credit and understanding and meeting obligations of tenancy as defined in lease terms.
2. Assist participant to view and secure housing as needed. This may include arranging or providing transportation. Assist participant to secure supporting documents/records, completing/submitting applications, securing deposits, locate furnishings.
3. Develop an individualized housing stabilization service provider plan based upon the housing assessment that includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies where other provider(s) or services may be required to meet the goal.
4. Participate in the development of the plan of care, incorporating elements of the housing stabilization service provider plan.
5. Look for alternatives to housing if permanent supportive housing is unavailable to support completion of transition.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Available only to participants who:

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

Limited to:

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Permanent Supportive Housing Agency

Appendix C: Participant Services

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

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

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

Certificate *(specify)*:

Community Psychiatric and Support Team
Other Standard *(specify):*
Permanent Supportive Housing (PSH) Agency under contract and enrolled with the Department of Health and Hospitals Statewide Management Organization for Behavioral Health Services plus either:

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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	Shared Living
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing

Provider Category:
Agency
Provider Type:
Shared Living
Provider Qualifications

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

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

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

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

The following activities do not qualify for the required experience:

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

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing

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

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

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

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

The following activities do not qualify for the required experience:

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

Verification of Provider Qualifications

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:
One-Time Transitional Services

HCBS Taxonomy:

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

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

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

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

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

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

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

The participant's support coordinator assists in accessing funds and making arrangements in preparation for moving into the residence.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
There is a one-time,life time maximum service of $3,000 per participant. Service expenditures will be prior authorized and tracked by the prior authorization contractor.

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

Security deposits are not to include rental payments.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transition Support Provider

Appendix C: Participant Services

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

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

Provider Category:

Agency

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

Certificate *(specify):*

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

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:**

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

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

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

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

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

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

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

Installation, participant training, a monthly monitoring fee, and the cost of maintenance are included in the Personal Emergency Response System service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Not available to participants who receive 24 hour direct care supports.

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

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

☑ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Emergency Response System

Appendix C: Participant Services

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

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

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

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers must comply with all applicable federal, state, county (parish) and local laws and regulations and meet manufacturer's specifications, response requirements, maintenance records,

and enrollee education. The provider's Response Center shall be staffed by trained professionals.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Fiscal Intermediary (Molina or the current contractor)

Frequency of Verification:
Initially, annually and as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:
Professional Services

HCBS Taxonomy:

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

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

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

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

Provider Category	Provider Type Title
Individual	Social Worker
Agency	Federally Qualified Health Center

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Agency
Provider Type:
Substitute Family Care
Provider Qualifications
License *(specify):*
Children:
Class A Child Placing Agency
Act 286 of 1985, LAC Title 48 Chapter 41

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

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

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

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

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Family and Child Services (Bureau of Licensing)

Department of Health and Hospitals (Health Standards Section)

Frequency of Verification:
Initially, annually and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Individual

Provider Type:
Physical Therapist

Provider Qualifications

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

Certificate *(specify):*

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

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

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

The following activities do not qualify for the required experience:

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Louisiana Physical Therapy Board

Frequency of Verification:
Initially, annually and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:

Individual

Provider Type:
Psychologist
Provider Qualifications
License *(specify):*
Psychology License
LA RS 37:2356
Certificate *(specify):*

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

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

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

The following activities do not qualify for the required experience:

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Louisiana State Board of Examiners of Psychologists
Frequency of Verification:
Initially, every two years, and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Individual

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

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

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

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

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

The following activities do not qualify for the required experience:

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

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Agency

Provider Type:
Rehabilitation Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Medicare Certification Letter confirming enrollment as either a Rehabilitation Agency or a Comprehensive Outpatient Rehabilitation Facility (CORF)

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

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

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

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

The following activities do not qualify for the required experience:

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

Verification of Provider Qualifications

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

Frequency of Verification:
Initially, annually and as necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Agency

Provider Type:

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

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

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

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

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

The following activities do not qualify for the required experience:

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

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Individual
Provider Type:
Social Worker
Provider Qualifications
License *(specify):*
Social Work License
LA RS 37:2701-2723
Certificate *(specify):*

Other Standard *(specify):*

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

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

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

The following activities do not qualify for the required experience:

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

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Services

Provider Category:
Agency
Provider Type:
Federally Qualified Health Center
Provider Qualifications

License *(specify):*

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

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

- Full-time experience gained in advanced and accredited training programs, (i.e., masters or residency level training programs) which includes treatment services for persons with a developmental disability;
- Paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);
- Paid, full-time professional experience in multi-disciplinary programs for persons with a

developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or

- Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

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

The following activities do not qualify for the required experience:

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

Verification of Provider Qualifications

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

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

HCBS Taxonomy:

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

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

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**

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

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Maintain compliance with:

- State minimum automobile liability insurance coverage,
- Possess a current state inspection sticker, and
- Possess a current valid driver's license.

May provide transport for up to three identified participants

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Initially for enrollment of providers

Appendix C: Participant Services

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

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

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

Check each that applies:

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

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

Appendix C: Participant Services

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

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

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

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

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

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

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

- Children's Code Title VI, Chapter 1, Article 601–606 and Title VI, Chapter 5, Article 609-611;
- LA. R.S. 14:403, abuse of children;
- LA R.S. 14:403.2 XI-B; abuse and neglect of adults (includes disabled adults); and
- LA R.S. 40:1300.53, "Criminal History Checks on Non-licensed Persons and Licensed Ambulance Personnel" The LA R.S. 40:1300.52 statute was amended by Act 816 of the 2006 Regular Legislative Session which required the criminal background check to now include a security check. The security check will search the national sex offender public registry. All direct support provider agencies are encouraged to become familiar with, and have on hand, the above mentioned statutes as a reference when hiring.
- ACT 816 finalized in 6/30/2006 added security checks for identification of sex offenders & authorized release of potential employees results to the employer.
- ACT 35 finalized in 6/15/2009 prohibited providers hiring any staff with a conviction for a list of 17 crimes (non- waivable offenses).
- Home & Community-Based Services Providers Minimum Licensing Standards (LAC 48: I Chapter 50) June 20, 2011 Emergency Rule with a final Rule published on January 20, 2012 Louisiana Register Vol. 38. No.1 January 20, 2012. This final HCBS Licensing rule includes:
  - o Criminal background checks and sex offender checks to be done on the owners and continued for all other non-licensed employees who provide personal care or other services and supports to persons with disabilities or the elderly.
  - o Includes providers being prohibited in hiring any staff without a criminal background and security check and cannot hire any staff with the specific convictions that are non- waivable (17 specific non-waivable convictions) and;
  - o Includes employee is not to work with client until results of criminal background check and security check is back and eligible for employment.
- Health Standards Section State Survey Agency conducts Investigations for Complaints and Monitoring for licensing surveys and reviews the staff's criminal background/security checks as well as the criminal background/security checks on the owners.

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

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, 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 Department of Health and Hospitals, Health Standards Section has a contractor who maintains the Direct Service Worker Abuse Registry for the state. Health Standards has a RN Program Manager who administers the Direct Service Worker Abuse Registry Program with oversight of the contractor.

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

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

Appendix C: Participant Services

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

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

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

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

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

Facility Type	
Shared Living	

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

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Shared Living

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Nursing	☐
Respite Services - Out of Home	☐
Professional Services	☐
Personal Emergency Response System	☐
Transportation - Community Access	☐

Waiver Service	Provided in Facility
Housing Stabilization Service	☐
Day Habilitation	☐
Dental	☐
Community Living Supports	☐
One-Time Transitional Services	☐
Host Home	☐
Supported Employment	☐
Companion Care	☐
Shared Living Services	☑
Environmental Accessibility Adaptations	☐
Support Coordination	☐
Housing Stabilization Transition Service	☐
Adult Day Health Care	☐
Assistive Technology/Specialized Medical Equipment and Supplies	☐
Prevocational Services	☐

Facility Capacity Limit:

6

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

Scope of State Facility Standards

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

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

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.*

- [ ] **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.

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

- Parent(s) of a minor child;
- Legal guardian of an adult or child with developmental disabilities; or

• Spouse

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

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

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

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

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

• Host Home:

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

• Companion Care:

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

○ **Other policy.**

Specify:

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

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

- Via the Louisiana Medicaid website;

- Through state facilitated stakeholder meetings regarding waiver services; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

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

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

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

Data Aggregation and Analysis:

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

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:
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 State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
For services provided in the 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 ICAP score for a participant is used to determine the participant's level of support needs which is then used to determine the participant's individual budget level. If a participant's level of support needs change, the ICAP is readministered to determine the participant's budget change.

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

• Intermittent – supports on an as needed basis. Characterized as episodic in nature, the person does not always need the support(s), or short-term supports needing during life-span transition.

• Limited – supports characterized by consistency over time, time-limited but not of an intermittent nature.

• Extensive – supports characterized by regular involvement (e.g., daily) in at least some environments and not time-limited.

• Pervasive – supports characterized by their constancy, high intensity, provision across environments, and potential life-sustaining nature.

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

Geographic factors do not affect the budget amount.

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

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

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

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) 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 setting assessments have not been completed. The timelines and plans for the settings assessment has been added to Attachment #2.