* DRAFT DOCUMENT * *

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

### 1. Request Information

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

B. **Program Title:**
**Residential Options Waiver (ROW)**

C. **Waiver Number:LA.0472**

D. **Amendment Number:**

E. **Proposed Effective Date:** *(mm/dd/yy)*
01/01/16

**Approved Effective Date of Waiver being Amended: 07/01/13**

### 2. Purpose(s) of Amendment

**Purpose(s) of the Amendment.** Describe the purpose(s) of the amendment:
Louisiana is submitting this amendment to:

1. Appendix B, Participant Access - create a reserved capacity group for individuals with Intellectual and Developmental Disabilities (I/DD) who have a Statement of Approval (SOA) through the Office for Citizens with Developmental Disabilities(OCDD)and who currently receive services via either the Office of Aging and Adult Services Community Choices Waiver(CCW) or Adult Day Health Care waiver (ADHC) to allow for transition into the OCDD Residential Options Waiver (ROW).

2. B,3,a. Adjusted the total numbers served years 3, 4 and 5
3. B,3,b. Adjusted the number of participants to align with years 3,4,5

4. Appendixes C,I, J: - Services
A. Addition of new service - Adult Day Health Care (ADHC) services,

- Appendix I-2(a): Revised Rate Methodology to include the added services
- Appendix J-2(i): Added information related to the new service

B. Appendix C: Clarification of available adult dental services
- Dental services – removing expanded dental services

5. Revised Appendix G-2,c Participant Safeguards: Seclusion,to complete the newly created section for data collection

6. Revised Appendix G-3 –Participant Safeguards: Medication administration to align with current state law/policy

7. Incorporates the Office of Citizens with Developmental Disabilities (OCDD) Home and Community-Based Services (HCBS) settings transition plan and addresses requirements of the HCBS Settings Rule.

8. Changed Waiver Assistance and Compliance Section(WCS)to Medicaid Program Support and Waivers (MPSW)

9. Changed OCDD Regional Waiver Office or Human Service Authority or District to Local Governing Entity (LGE)name change only

## 3. Nature of the Amendment

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

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

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

- ✓ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ✓ **Add/delete services**
- ✓ **Revise service specifications**
- ✓ **Revise provider qualifications**
- ✓ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ✓ **Other**

Specify:
Create a reserved capacity group for individuals with Intellectual and Developmental Disabilities (I/DD) who have a Statement of Approval (SOA) through the Office for Citizens with Developmental Disabilities (OCDD) and who currently receive services via either the Office of Aging and Adult Services Community Choices Waiver (CCW) or Adult Day Health Care waiver (ADHC) to allow for transition into the OCDD Residential Options Waiver (ROW).

Add Adult Day Healthcare service

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

## 1. Request Information (1 of 3)

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

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

**C. Type of Request: amendment**

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

○ **3 years** ● **5 years**

**Draft ID:** **LA.005.01.03**

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

**E. Proposed Effective Date of Waiver being Amended: 10/01/12**
**Approved Effective Date of Waiver being Amended: 07/01/13**

## 1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☐ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

## 1. Request Information (3 of 3)

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

Select one:

● **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

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

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

Specify the program:

**H. Dual Eligiblity for Medicaid and Medicare.**

Check if applicable:

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

## 2. Brief Waiver Description

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The purpose of the Residential Options Waiver, a 1915 C waiver, is to assist service participants in leading healthy, independent and productive lives to the fullest extent possible; promote the full exercise of their rights as citizens of the state of Louisiana; and promote the integrity and well-being of their families. Services are provided with the goal of promoting independence through strengthening the participant's capacity for self-care and self-sufficiency. The Residential Options Waiver is person-centered incorporating the participant's support needs and preferences with a goal of integrating the participant into their community. The Residential Options Waiver provides opportunities for individuals with developmental disabilities to transition from ICFs-DD into home and community based services by providing residential and support services.

The objectives of the Residential Options Waiver are to:
• Promote independence for participants through the provision of services meeting the highest standards of quality and national best practices, while ensuring health and safety through a comprehensive system of participant safeguards;
• Offer an alternative to institutionalization and costly comprehensive services through the provision of an array of services and supports that promote community inclusion and independence by enhancing and not replacing existing informal networks;
• Support participants and their families to exercise their rights and share responsibility for their programs regardless of the method of service delivery; and
• Offer access to services on a short-term basis which would protect the health and safety of the participant in the event that the family or other caregiver were unable to continue to provide care and supports.

The Department of Health and Hospitals (DHH) Bureau of Health Services Financing is the Single State Medicaid Agency which maintains administrative and supervisory oversight of the Residential Options Waiver. BHSF (Medicaid) has a Memorandum of Understanding with the Local Governing Entity (LGE) formerly known as Districts and Authorities, along with the Office for Citizens with Developmental Disabilities, which specifies the roles and responsibilities of each party and the methods BHSF will use to ensure the operating agency performs delegated waiver operations and administrative functions in accordance with the approved waiver application, rules, and policies. This agreement has been in effect since 2010.

Services are accessed through a single point of entry within OCDD LGE. All waiver participants choose their Support Coordination and Direct Service Provider Agencies through the Freedom of Choice process. All services must be prior authorized and delivered in accordance with an approved Plan of Care. The Plan of Care is approved at the LGE. Prior authorization is completed through an independent entity contracted by DHH that also maintains the service data on all waivers for the developmental disabilities population.

The ROW includes Participant Direction of Services as an optional service delivery method. The participant-directed service is Community Living Supports.

## 3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

## 4. Waiver(s) Requested

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

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

- ○ **Not Applicable**
- ● **No**
- ○ **Yes**

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

- ● **No**
- ○ **Yes**

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

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

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

## 5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

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

F. **Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

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

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

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

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

## 6. Additional Requirements

*Note: Item 6-I must be completed.*

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

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

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

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

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

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

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

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

severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
Public input was included in development of the waiver by establishment of a statewide ROW Stakeholder Workgroup. The Workgroup members were chosen at a statewide stakeholder roll-out meeting on the ROW pursuant to an invitational letter requesting representatives from each of the following groups:

- Family, Advocacy, State Advisory and other developmental disability organizations such as the Developmental Disabilities Planning Council, the State Protection and Advocacy Agency, the Community Living Ombudsman Program, ARC of LA, AAMR of LA, Families Helping Families of LA and the LA. Rehabilitation Services;
- Individuals with disabilities and family members, especially those persons waiting for waiver services and current residents of ICFs-DD interested in moving into less restrictive residential waiver options;
- ICFs-DD Waiver and Support Coordination provider organizations; and
- Regional Administrative Units, Supports and Services Centers, State Medicaid and OCDD Statel Office representatives.

A group of Core Stakeholders was drafted at the initial meeting to assist with service criteria and definitions, target group identifications, rates etc. The Workgroup members were also asked to relay feedback and promote two-way communication between their constituents in the various stakeholder groups. Additionally, they were specifically asked to communicate issues, concerns and recommendations from the various stakeholder groups to the OCDD staff assigned to complete the ROW application.

During meetings and listening sessions, questions and comments were solicited regarding waiver services and processes. The application renewal took into account information obtained from the meetings/listening sessions. Information discussed in the meetings included vocational services, provider capacity, self-direction, etc. Meeting participants were able to discuss what was working well in the program and what needed changing. Included in the meetings/listening sessions were consumers, parents of consumers, Families Helping Families organization, Louisiana Advocacy Center, Developmental Disability Council, Louisiana Workforce Commission, Department of Education, Louisiana Rehabilitation Services, Louisiana State University Health Sciences Center, and providers. Louisiana has become an Employment 1st state and is in the process developing policy and processes to reflect the changing ideals. Louisiana is in the process of finalizing supported employment definitions, services rates, and services units. This information will be updated in OCDD waiver applications once the Employment 1st consortium has completed revising employment definitions and developing a plan of implementation. Identification of additional provider types available in the state was also identified and included in the application renewal. Dates include October 11, 13, 18, 19, 25, 27, November 30, and December 2, 14, 15, 2011.

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

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

## 7. Contact Person(s)

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

**Last Name:** Levelle

**First Name:** Jeanne

**Title:** Section Chief

**Agency:** Bureau of Health Services Financing

**Address:** 628 N. 4th Street

**Address 2:** P.O. Box 91030

**City:** Baton Rouge

**State:** **Louisiana**

**Zip:**

70821

**Phone:**

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

**Fax:**

(225) 342-9168

**E-mail:**

jeanne.levelle@la.gov

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

**Last Name:**

Thomas

**First Name:**

Mark

**Title:**

Assistant Secretary

**Agency:**

Office for Citizens with Developmental Disabilities

**Address:**

628 N. 4th Street

**Address 2:**

**City:**

Baton Rouge

**State:** **Louisiana**

**Zip:**

70821

**Phone:**

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

**Fax:**

(225) 342-8823

**E-mail:**

Mark.thomas@LA.GOV

## 8. Authorizing Signature

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

**Signature:**

State Medicaid Director or Designee

**Submission Date:**

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** Louisiana

**Zip:**

**Phone:** **Ext:** ☐ **TTY**

**Fax:**

**E-mail:**

## Attachments

**Attachment #1: Transition Plan**

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

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

Specify the transition plan for the waiver:

Transition Plan for OAAS waiver recipients into OCDD's Residential Options Waiver

Criteria and Reasoning behind the Transition

Louisiana is submitting an amendment to the Residential Options Waiver (ROW) that will create a reserved capacity group for individuals who currently receive services via the Community Choices Waiver (CCW) or Adult Day Health Care waiver (ADHC). The CCW and ADHC waiver programs are operated by the Office of Aging and Adult Services (OAAS), but the ROW waiver program is operated by the Office of Citizens with Developmental Disabilities (OCDD). In order for an OAAS waiver recipient to make this transition, they must have an I/DD diagnosis, a Statement of Approval (SOA) by OCDD, and currently be receiving CCW or ADHC services. This transition will improve access to I/DD services for these individuals and contribute to more efficient operation of the State's home and community-based services delivery system. This change will result in the transition of approximately 235 individuals who will have greater access to services specifically designed to support their needs as persons with ID/DD.

This plan to transition the aforementioned individuals was initially introduced to stakeholders in February 2015. In an effort to promote transparency and stakeholder buy-in and input, the plan was also shared during public forums held across the state on February 11th and February 20th of 2015. During these forums, the idea was received positively by stakeholder groups. The transition plan being proposed in this waiver amendment will be posted for public comment prior to submission to CMS.

Benefits of Transition

The ROW will afford recipients access to services which are not available through either the ADHC or CCW, including Supported Employment, Host Home Services, Psychology Services, Registered Dietician Services, and Social Worker Services. In addition, OCDD is requesting through this amendment the addition of Adult Day Healthcare as a service in the ROW to ensure continuity for those individuals who choose to continue to receive that service. Another benefit is the consumer directed option is now available to those individuals transitioning from the ADHC waiver where it was not an option before. Finally, the ROW offers the opportunity to secure more services with a higher expenditure cap, than has been available in either the ADHC or CCW waivers.

Crosswalk Comparisons of the Waivers

The following charts provide an abbreviated comparison of the 3 waivers:

Maximum Expenditure Limit Comparison

| ADHC | CCW | ROW |
|---|---|---|
| $26,640 | $39,445 (Based on MDS assessment RUG score) | $61,753 (Based on ICAP level) |

Average Cost Per Recipient

| ADHC | CCW | ROW |
|---|---|---|
| $11,698 | $22,408 | $26,913 |

Service Comparisons

The chart below lists and compares services available under the ADHC and CCW with ROW services. None of the services currently available in the ADHC or CCW will be eliminated, however some services may be provided under a different and more comprehensive service in the ROW. The comprehensive services are denoted in the footnotes of this chart.

Waiver Service Comparison Chart

Chart

| ADHC / CCW Service | ADHC | CCW | ROW | Cross- Walked ROW Service |
|---|---|---|---|---|
| Adult Day Health Care | X | X | X | Adult Day Health Care |
| Case Management | X | X | X | Support Coordination |
| Transition Supports | X | X | X | Transition Supports |
| Environmental Accessibility Adaption | - | X | X | Environmental Accessibility Adaptation |
| Home Delivered Meals | - | X | X(1) | Community Living Support |
| Monitored In-Home Caregiving | - | X | X(2) | Companion Care |
| Nursing | - | X | X | Nursing |
| Personal Assistance Services- 1:1 | - | X | X(3) | Community Living Support |
| Personal Assistance Services- Shared | - | X | X(4) | Community Living Support |
| Personal Emergency Response System | - | X | X | Personal Emergency Response System |
| Permanent Supportive Housing | - | X | X | Permanent Supportive Housing |
| Respite | - | X | X | Respite |
| Self-Directed Option | - | X | X | Self-Directed Option |
| Specialized Medical Equipment/Supplies | - | X | X | Specialized Medical Equipment / Supplies |
| Occupational Therapy | - | X | X | |
| Physical Therapy | - | X | X | |
| Speech, Language Therapy | - | X | X | |

X(1) - Service for Home Delivered Meals is not necessary in the ROW. If an individual requires assistance with meal preparation, this is provided through Community Living Support in the ROW.

X(2) - Monitored In-Home Caregiving service in CCW is a similar service to Companion Care in the ROW.

X(3) - Personal Assistance Services 1:1 in CCW is a similar service to Community Living Support in ROW.

X(4) - Personal Assistance Services –Shared in CCW is a similar service to Community Living Support in ROW.

Community Living Supports (CLS) as defined in the ROW manual are a residential option for recipients and includes self-help skills (which includes ADLs and IADLs), socialization skills, cognitive and communication tasks, and acquisition of appropriate positive behavior supports. These supports can be provided as individual supports or as shared supports. These supports focus on Active Treatment to build skills and independence for persons with Intellectual/Developmental disabilities. Personal Assistance Services (PAS) as defined in the CCW manual include assistance and/or supervision necessary for recipients with functional impairments including supervision and/or assistance with ADLs and IADLS, protective supervision, supervision while outside of the home, and extension of therapy services. These supports can be provided as individual supports or as shared supports. Additionally, Companion Care is defined as a residential option for people who do not typically require 24 hour support and is provided by a companion who lives in residence with recipient to provide supports as outlined in CLS above. Monitored In-Home Caregiving is defined in CCW as service provided to recipient living in private home with principal caregiver who is responsible for services as outlined in PAS above. Based on these definitions, individuals will be able to continue to receive assistance for tasks as outlined in their plans of care.

The services provided in the amended waiver (ROW) will not be available in a lesser amount than is currently available in the CCW. Therefore, there will not be a negative impact on the health and welfare of recipients transitioning into ROW. In fact, as previously stated, to ensure continuality of service and to minimize disruption to those individuals with OCDD statements of approvals and who are making the transition from CCW or ADHC, the Adult Day Health Care service is being added to the ROW. Furthermore, the ROW affords people a wider scope of services (listed earlier in this document) which are not available in either the ADHC or CCW waivers.

Service Delivery Methods

| ADHC | CCW | ROW |
|---|---|---|
| Provider Managed | Provider Managed | Provider Managed |

Transition Plan Details and Timetable

In preparation for this transition, all recipients, families, case managers, local governing entities, and providers who will be impacted by this transition will receive a written communication from DHH. Each of these groups of stakeholders will receive a different letter which will specifically address impact to their situation and provide guidance on next steps in this process, and a phone contact will be provided to address additional questions. This communication will occur at the same time public notice of this transition is given. Throughout the process, stakeholders will have an opportunity to provide feedback on the proposal, and all feedback will be taken into consideration.

Additionally, beginning 90 days prior to targeted implementation date, training will be provided to OAAS Support Coordinators regarding available ROW services so that discussion and planning for transition with recipients and family members can begin prior to implementation. In addition, OAAS Support Coordinators will begin to build a file of all relevant documents, including but not limited to current Plan of Care, relevant assessments, and medical / behavioral / therapy documentation that will transfer with the individual to assist in ensuring a smooth transition. Technical assistance will be available throughout the process to the Support Coordinators through OCDD and OAAS. In addition, fact sheets, comparison charts, and frequently asked questions will be made available to individuals and families. Licensed OAAS providers will be able to add the ROW subspecialty so that there can be a continuation of services. The communication that is sent to providers who currently offer services to recipients of ADHC and CCW waiver will provide instructions on this process. DHH will streamline this process as much as possible to ensure continuity of services. In addition, Prior Authorizations that are in place for OAAS services will remain effective until the ROW plan of care is developed and services authorized to ensure no loss in services during the transition.

Individuals will transition from CCW or ADHC Waiver to ROW in a phase-in approach during each individual's annual CPOC meeting. OCDD and OAAS Support Coordinators will work together to ensure person-centered planning occurs related to the transition with a focus on maintaining independence and continuing to live safely in the community. OCDD Support Coordinators will take the lead in development of Comprehensive Plan of Care for individuals who are transitioning. Local Governing Entities will complete ICAP assessments for individuals transitioning 30 – 60 days prior to the transition. The goal is to phase in all of the identified individuals over the course of the first year following implementation. Fair Hearing rights will be provided to each person during person-centered planning meetings as ROW plans of care are developed.

During this phase-in period, individuals with OCDD Statements of Approvals and who would have been eligible to begin receiving CCW or ADHC services or are currently on either the CCW or ADHC waiting list, will be placed on the ROW Request for Services Registry, maintaining their current protected date. At the current time, there are no individuals on the ROW Registry; however, the ROW does allow for a registry to be enacted. Therefore, it is not anticipated that there will be a significant delay in initiation of ROW services. The waiting lists for both CCW and ADHC are substantially longer than the waiting list for ROW will be, so it is certain that individuals will receive services sooner through the ROW waiting list.

DHH is confident in this action as part of its overall plan to improve the identified individuals' access to I/DD services and create greater efficiencies within the State's home and community-based services delivery system.

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

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

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

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

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

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

Louisiana assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. Louisiana will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

The Statewide Transition Plan submitted to CMS on March 17, 2015, provides an in-depth review of the Settings Rule and includes detailed information about public input, assessment and review, and remediation efforts. OCDD invites reviewers to seek greater details about the OCDD plan and how it relates to the Statewide Transition Plan. The information here represents only the highlights of the OCDD Plan.

A) Stakeholder Engagement:

OCDD set about developing public comment phase. To that end, OCDD created a website on October 6, 2014 and published information about the new Settings Rule and the plan to comply. Comments on this information were due on February 28, 2015. Providers were notified via an e-mail blast on February 3, 2015. Three public forms were held on November 17, 2014, February 11, 2015 and February 20, 2015. Five provider meetings were held from October 20, 2014 through February 12, 2015. The comment period for the Supports Waiver, Residental Options Waiver, the New Opportunities Waiver, and the Children's Choice Waiver ran from November 21, 2014- February 28, 2015. There were no additional comments received during the additional time that comments were collected for the Residential Options Waiver. Forums were advertised on the website that was established for the Transition Plan, blast emailed to all providers, and shared through the Developmental Disabilities Council and other advocacy organizations Listserv.

Also, the transition plan was presented at five provider meetings with OCDD providers, stakeholders and Support Coordinators on 10/20/14, 11/6/14, 1/13/15, 1/14/2015 and 2/12/15.
Comments could be received either at the public forums, through email, mail or telephone call.

OCDD received several email questions which are attached with answers.

Below is a paraphrased summary of comments and/or questions and answers surrounding the Supports Waiver that was received at the public forums and provider meetings:
If an individual has been at our facility for 30 years and neither the individual nor the family want the individual to go work in the community, does the individual have to go into the community?
The person has choice and through a person-centered process a plan should be developed for each individual. The individual does not have to go to work but it must be explored with the person on a regular basis his or her desire for employment and not just a one-time discussion. All options for work must be explored with the person. The person does not have to go into the community but must be offered choice.
What about individuals who are total care and parents do not want them to interact with others outside the facility?
Through a person-centered process, the individual will establish a plan of what they want to do. Options must be provided to them and given a choice of what they would like to do with their day.
What incentives are being given to employers in the community to hire individuals with disabilities?
There are several work incentives such as a tax-credit that are offered to employers. Louisiana Rehabilitation Services offers different programs that can be an incentive to employers.
Will facilities be closed down?
Facilities are not being closed because of this rule, but must come into compliance in order to continue receiving waiver funding.
What's going to happen to prevocational services?
Prevocational services will take on a new definition and will be time limited to 4 years in the waivers.
Will we be able to still continue day habilitation services and if so how often do the individuals have to go in the community?
Day habilitation services will continue but will have a new definition. Persons in day habilitation will have a choice in how they spend their time and what they would like to do. There is not a prescribed amount of time that is to be spent in the community in order to be considered integrated; however day habilitation must be integrated and must be based on each individual's choice in how they spend their day.
We operate a plant nursery on the grounds of our facility, but it's open to the public and the public can come and go as they please. The nursery is run by a non-disabled manager and then individuals with ID/DD work there along with their staff. At this time, we are getting ready to begin paying the individuals minimum wage. Does this seem like a business that would fit the requirements of CMS?
Each agency will take part in a self-assessment process which will help them to determine if the agency/business will meet the new guidelines set by CMS. If after completion of the self-assessment the provider has additional questions or needs guidance OCDD will be available to provide TA.
Our agency is in the rural part of the state and there are not any businesses in the area. What are we supposed to do with the individuals that we serve at the facility? They currently work on a contract. Can they continue to work on that contract? If not, what can we do to help our individuals because if we are made to stop serving them then they won't have anywhere to go.
Each person that you serve must be given choices that are available to them and through the person- centered process; they must be allowed to decide what they would like to do with their day. If the person continues to work on the contract it must become integrated. Other work options must be explored with the individual and the individual must have the ability to decide for themselves what they wish to do.
Will the supervisor of a work crew, who is non-disabled, be considered integrated?
NO
What if the individuals interact with non-disabled folks along the way to work? For example: stopping at stores along the way to buy lunch or snacks. Is this considered integrated?
No, this is not considered integrated
What if group homes are located on the same grounds as the offices and the day programs? Does this meet the rules?
Through the completion of the provider self- assessment tool, providers will be able to understand if they are in compliance or exactly what is considered non-compliant. OCDD will provide TA to providers who have unique situations and need additional guidance.
Do you plan to do outreach to families?
Yes, we have and will continue to do so. OCDD is more than happy to meet with families if the provider sets up a meeting.
Will you come out to share this information with families at our facility?
Yes
Vocational providers shared that it's against the rules if you transport individuals across parish lines in vans that are provided by Department of Transportation. Will we be talking with DOTD?

More information and research will need to be obtained in order to understand the policy of the vans that are obtained through the DOTD. But individuals will have to be given an informed choice and explained their options.
When will the provider self-assessment be ready?
OCDD is planning to release the self-assessment during March along with providing training to the providers on how to complete the assessment.
Will the results of the provider's self-assessments be shared?
Yes, the results will be posted on the website that currently is established for getting out the transition plan information.
Concerns were voiced about providers not being a part of the planning process and not being included in what the individuals chooses to do regarding vocational choices.
Individuals have the right to be informed of their choices for services as well as providers and through the person-centered process; they will be afforded this right. Providers will be included once they are chosen and the provider can choose not to provide the service if they want to. The PCP essentially goes on throughout the year and is not a one-time meeting where the POC is updated/amended.
OCDD is still discussing how the surveys will be distributed.
It was shared that parents/families prevent individuals from being integrated and what will be done to help this?
The person-centered process will be utilized to inform them of their choices and establish their interest and goals.
Is licensing going to be addressing the new settings guidelines as well? It was shared that the providers get 'written up' for including individuals with non-disabled peers.
Meetings will be scheduled with Health Standards to address the new rule that CMS issued and changes will be made as necessary.
Is there anything in the transition process that will hold SCs accountable? Not just a 'pretty plan'
Person Centered planning will continue to be utilized and if necessary additional training on PCP may be provided.
How are we going to get the community to accept our individuals and also hire them?
Immersing our individuals in the community and not segregating them will go a long way in helping the community to accept our individuals.
Concerns were voiced by several participants of the public forums around individual's safety in the community and being with people in the community as part of a volunteer position or just doing community activities. Also, there were concerns about having volunteers or the public come into their facilities that have not passed back ground checks. Just overall concern about integrating the individuals they serve and keeping them safe.
You will continue to have to do everything that you do now to ensure health and safety and provide the necessary staff ratio as established, but at the same time, it does not negate the fact that our individuals must become part of the community and that we must move away from segregation.
Are there going to be provider trainings?
Yes, provider trainings and technical assistance will continue. Round tables in each region for vocational providers will be scheduled to provide an additional level of assistance.

General Comments/Suggestions:

Vocational providers expressed their concerns about rates and billing because they believe that having to do more integration and being in the community is going to cost them more money, such as they will be using their vans more often therefore their insurance will change.
OCDD will monitor this but at this time there is not a plan to increase rates.
Several providers suggested letting them know when the participant surveys go out so that they can tell families to be on the lookout for it. They stated that a lot of families will just throw it away if they don't know what it is.

Advocacy Center Comments on OCDD Transition Plans
December 17, 2014:

1. The Advocacy Center is submitting these comments regarding the State of Louisiana's "transition plans" for complying with the home- and community-based settings requirements for services under existing § 1915(c) waivers administered by the Office for Citizens with Developmental Disabilities. The State has failed to submit transition plans in compliance with the regulations promulgated by the Secretary 79 Fed. Reg. 3028-39 (January 16, 2014)
CMS issued the final rule with a fact sheet on January 10, 2014. At the time, states were put on notice that a Statewide Transition Plan to ensure compliance was required and must be submitted to CMS on or before March 17, 2015. States were advised that additional information on the transition process would be forthcoming and, in particular, toolkits would be developed and distributed on: 1) Residential Settings; and 2) Non-Residential Settings. States were given notice that if an amendment to an existing approved waiver is submitted from January, 2014 through March 17, 2015, a transition plan must be submitted with the amendment. States were notified that additional information in the form of a toolkit would be issued soon by CMS.
While Louisiana's overall Transition Plan is not due to be submitted to CMS until March 17, 2015, OCDD wished to develop an amendment to the Supports Waiver; hence a separate transition plan was needed specifically for the amendment.
The State has posted four documents on its website regarding transition plans for services to individuals with developmental disabilities (http://new.dhh.louisiana.gov/index.cfm/page/1991).

2. Three of the four documents are referred to as "transition plans":
OCDD Home and Community-Based Services Setting Transition Summary/Description: This announcement introduces the new rule and describes what the new rule means to participants, communities, and providers. It further discusses settings owned and controlled by service providers. It specifies certain settings in which HCBS cannot be provided. The OCDD website provides additional information on OCDD's approach to developing the transition plan and assures that on-going opportunities for the public to receive information in a transparent manner will be continuous throughout the transition period. The public is encouraged to submit comments. Comments for the Support Waiver ended February 27, 2015. Comments for the ROW ended March 12, 2015.
OCDD Home and Community-Based Services Setting Transition Plan: This website address provides the public with a detailed action plan of the Statewide Transition Plan for all DD waivers except the Supports Wavier. It provides the public with information on the specific action items, a description of the action items, proposed start dates and proposed end dates. See comments deadlines above for dates.

OCDD Supports Waiver Transition Plan: This website address offers a detailed work plan complete with action item descriptions, proposed start dates and proposed end dates.

3. The fourth document is a draft amendment to one of Louisiana's existing waivers, the Supports Waiver. There is no explanation on the website, or in any of the documents that are denominated "transition plans," of how this draft amendment relates to bringing the Supports Waiver into compliance with the home- and community-based settings requirement. A review of the draft amendment did not reveal any changes that relate to the requirements of the January 2014 regulations.
The Supports Waiver required a transition plan in order to be amended. That is why there is a separate document for the SW. Also, as a requirement of CMS, the SW amendment must be posted on the website for viewing and comments. There are no changes to bring into compliance as those changes have already been completed in the SW renewal effective July, 2014.

4. The website indicates that public comments or input must be provided by December 17, 2014. These documents provide no substantive information as to whether or not the State deems its waivers to be in compliance with the January 2014 regulations, or any detail as to how the State proposes to bring them into compliance. None of these plans contains the required elements of a transition plan.
The Statewide Transition Plan is the vehicle through which states determine their compliance with the regulation requirements for home and community-based settings at 42 CFR 441.301(c) (4) (5) and 441.701(a) (1) (2), and describe to CMS how they will comply with the new requirements. A Statewide Transition Plan includes the state's assessment of the extent to which its regulations, standards, policies, licensing requirements, and other provider requirements ensure settings that comport with the new regulation. The Statewide Transition Plan also describes actions the state proposes to assure full and on-going compliance with the HCBS setting requirements, and sets forth specific timeframes for identified actions and deliverables. The Statewide Transition Plan is subject to public input, as required with the regulation. States are given until March 17, 2019 to comply with the new regulation but will be obligated to develop a transition plan that aggressively progresses to compliance.
The CMS Toolkit was released September 5, 2014. This provided states with the first real insight into CMS expectations about the content of the Statewide Transition Plan. The Plan must include: 1) a detailed description of the state's assessment of compliance with the home and community-based settings requirement and a statement of the outcome of that assessment; and 2) a detailed description of the remedial actions the state will use to assure full compliance with the home and community-based setting requirements, including timelines, milestones and monitoring processes, and remedial activities.
Additional information about Residential Setting was sent to states on March 20, 2014, information about Non-Residential Settings was formulated December 17, 2014.
We feel the information provided on the website meets the CFR requirements for public notice. This is not a one-time announcement. As OCDD continues to work through the action items described in the charts, the public will be kept apprised of progress and will be offered the opportunity to submit questions and comments. An assessment of each wavier and assessment of each provider will be conducted during the first year of the transition plan and notification to the public will be continuous throughout the Statewide Transition Plan process.
The date for the overall transition plan was December 17, 2014; however, the SW was originally set for December 21 but later extended to February 28. This transition plan does envisage that OCDD will have to evaluate providers and their compliance upon their completion of self-assessments and monitoring. This process is laid out over the next year of the transition plan. During that time, an addendum will be made to the plan if needed, describing in more detail what will happen next.

5. It is not clear which of these documents, if any, the State intends to use as transition plans under 42 C.F.R. §441.301(c) (6). This may because OCDD intends to apply for approval of a § 1115 Demonstration Project in preparation for a move toward managed long-term services and supports. Apparently, the State believes that this fact excuses it from complying with the requirement that it bring services under its existing waivers into compliance with the rule. We would simply note that the January 2014 Rule does not contain an exception for States that intend to apply for § 1115 Demonstration waivers. It requires all States with existing waivers to submit plans that contain an assessment of current compliance and timetables for addressing noncompliance by January 16, 2015.
You are correct in that these documents are "draft" and will most likely be amended based on public comment. OCDD understands and is in compliance with CMS' rule. We understand that we are not being excused from meeting CMS' rule and requirements.

6. The first step in any transition plan is for the State to determine its current level of compliance with the settings requirements in each waiver. The "Toolkit" published by CMS states that the State should provide a written description to CMS, including in this written description its assessment of the extent to which its standards, rules, regulations, and other requirements comply with the Federal HCBS settings requirements. As you will note in OCDD's transition plan, OCDD will be assessing compliance of each service provided in the HCBS setting. We plan on issuing a self-assessment to each provider, conducting random site reviews, and distributing participant surveys to determine the level of compliance. These actions meet the requirements of the CFR and will be available for public input.

6. This description is a required part of the transition plan, and should be available for public comment.
The public will have an opportunity to review the self-assessment and the participant survey prior to distribution.

7. The OCDD Supports Waiver Transition Plan states that by November 30, 2014.
OCDD will assess all HCBS rules/regulations, related licensing, and policies/procedures to determine degree of compliance with the HCBS rule for the Supports Waiver.

8. The OCDD Home and Community-Based Services Setting Transition Plan states that by October 31, 2014 Louisiana will assess all HCBS rules/regulations and policies/procedures. However, no results of any such assessments have been published, so the public has been given no opportunity to review or comment on this aspect of the plan.
The assessments of the rules and services definitions of all 4 waivers were conducted in-house. Notes were made where changes needed to be made to come into compliance. OCDD will make all information available for public comment. In addition, the plan has been revised based on new guidance given by CMS. Revisions are currently being made in the Transition Plan timelines.

9. The OCDD Home and Community-Based Services Setting Transition Plan also states that by November 1, 2014.

Louisiana will draft and finalize informational letters describing the proposed transition plan, appropriate HCBS settings, deadlines for compliance, and technical assistance availability. Louisiana will also offer a public stakeholder meeting and invite participants and their families, advocacy groups, service providers, support coordination, local governing entities, etc.

10. There was a stakeholder meeting on November 17, 2014, but it did not involve a discussion of proposed transition, appropriate HCBS settings, deadlines for compliance, and technical assistance availability.
During the November 17, 2014 meeting a presentation was made and included the following: 1) description of the new rule; 2) introduction of the Statewide Transition Plan and the process Louisiana would be adopting to effectuate it; 3) an examination of what all states must do to comply with the new rule; and 4) introducing an outline method for public input. In addition to the meeting held on the 17th, 2 additional forums were held to discuss the transition.

11. Other than these deadlines, which have already passed without the State's having presented any of the information for public comment; the plans simply set forth some desired steps, not to attain compliance with the regulations, but to assess current compliance. The only actions the "plans" describe are that the State will require HCBS providers to submit "corrective action plans." But the plans do not provide any detail at all about what sorts of corrective action will be necessary.
As mentioned the deadlines are being internally reviewed. These will be final once the Statewide Transition Plan is complete and all information will be available to the public via the website. We have built a robust assessment and evaluation process into our settings reviews. If compliance issues are identified, correction action plans will be developed specific to providers, however; our transition plan does include language on broad-based corrective action strategies.

12. These regulations were promulgated almost a year ago. Instead of evaluating its existing services so that it could present a transition plan for public comment, the State has apparently done nothing.
It is extremely obvious that some of the State's services under existing waivers fail to comply with the home and community-based settings requirements. For example, day habilitation and prevocational services under the NOW, the Supports Waiver, and the ROW are often provided in completely segregated settings, and more appropriate integrated services are not offered, or are extremely limited. It should not have taken the State a year to figure out how to figure this out. Yet the "transition plans" do not even propose to have data as to whether or not different services comply with the regulation available to the public until December 31, 2015.
CMS has been slow to provide States with detailed information about the action to be taken to come into compliance with the new Rule due to the complexities of the Rule. Please keep in mind, CMS issued the toolkit on September 5, 2014 and guidance on the non-residential setting on December 17, 2014. For the state to take action prematurely, might have resulted in participant and provider confusion, and individuals being transitioned unnecessarily. Only about 20% of the states have approved Statewide Transition Plans at this time. Louisiana's progress mirrors the progress of most other states. The law gives states until March 17, 2019 to comply with the regulation. We are aware that services are sometimes segregated, however; we will have a period of up to 5 years to come into compliance with regulations. That is the deadline for compiling the information obtained from self-assessments and on-site visits. Once this information is compiled it will be shared on the website.

13. If these documents satisfy the requirement that the States submit transition plans within a year of the effective date of the January 2014 regulations, to bring existing waivers into compliance with the regulations, after first making the transition plans available for meaningful public input, then that requirement is meaningless.
The Statewide Transition Plan that is due to CMS on March 17, 2015 simply outlines the approach the state will take to implement the Plan. CMS has been providing direction to states during the last year. There are certain components that CMS feels must be in the plan and these include: 1) a means for public input; 2) an assessment of each service; 3) conducting self-assessments with certain criteria included; 4) development of strategies for remediation; and 5) development of a quality assurance plan to ensure compliance. The Statewide Transition Plan will include all the CMS requirements and Louisiana will throughout the implementation phase keep the public apprised of related activity.

14. One of Louisiana's waivers that offer services in settings that do not comply with the January 2014 regulation is the Supports Waiver 0453-R0200. This waiver was submitted for a five-year renewal on June 3, 2014, making the transition plan due, according to the January 2014 regulation, on October 1, 2014.
All waiver amendments must be submitted to CMS 90 days prior to renewal. We did not meet this cutoff date; therefore the transition plan was not due in October. Further, according to CMS interpretation, a transition plan must accompany any amendment submitted prior to March 17, 2015. Hence this is why the transition plan is being submitted at this time with the Supports Wavier.
We appreciate your interest and look forward to working with you closely on the successful implementation of the Statewide Transition Plan. Updated information specific to the current transition plan should be posted on the website no later than March 20, 2015.

B) Assessment and Review:

OCDD identified the following services in the Supports Waiver as setting that may be compliant, or with changes will comply with the HCBS characteristics: 1) habilitation; 2) day habilitation:, 3) pre-vocational services; and 4) supported employment group.
An initial State-level assessment of standards, rules, regulations, and other requirements to determine if they are consistent with the federal requirements has been accomplished. Louisiana staff reviewed licensure and certification rules and operations. Staff reviewed such documents from October 1, 2014 through November 30, 2014. During this review, processes were carefully examined and it was determined that modifications to licensure and certification rules and program operations were not needed. Further, provider qualifications were assessed. Modifications are not needed in this area.

Self-Assessments:
After carrying out the analysis of the services, DHH developed a provider self-assessment for residential settings, completed on September 22, 2014 and one for non-residential settings, completed on January 11, 2015. These may be found in Appendix C of the Statewide Transition Plan. OCDD intends to solicit stakeholder input via the website beginning on March 18, 2015 with comments to be returned by April 18, 2015. The self-assessments will be distributed to providers from April 19, 2015 to April 30, 2015.
The links to the self assessments are as follows:

http://new.dhh.louisiana.gov/assets/docs/OCDD/waiver/OCDDHomeandCommunityBasedServicesSettingResidentialAssessmentoolDRAFT.pdf
http://new.dhh.louisiana.gov/assets/docs/OCDD/waiver/OCDDHomeandCommunityBasedServicesSettingNonResAssessmentoolDRAFT.pdf

Site Visits:
DHH will conduct site visits to validate self-assessments. Site visits will begin May 1, 2015 and continue until September 30, 2015. During the site visits, staff will determine if the elements of the HCB Settings Rule are in compliance or with additional modifications, can achieve compliance. Participant Surveys:
Since Louisiana does not assume any of the HCBS settings meet the new regulations, validation will also include actively engaging individuals receiving Medicaid-funded HCBS services. Opinions and insights on how providers are meeting the HCBS requirements will be determined by developing a participant survey. This survey is currently under development and stakeholder input will be critical. Once public comments are received and modifications made based on those comments, the surveys will be distributed from July 1, 2015. A complete set of instructions will be forwarded with each survey and training will also be available. OCDD surveys will be returned by October 1, 2015.
Once self-assessments, site visit findings, and participant surveys are analyzed, the State will begin developing a final report for CMS. State final reports are due at various times depending on the Office. Final reports from OCDD will be forwarded to CMS on January 31, 2016.

C) Remediation:

Ensuring Providers are Compliant:
Once OCDD reviews the self-assessment, site visit results, and participant survey, an analysis of the responses will begin. Office staff will determine if: 1) the setting is in compliance; 2) the setting will be in compliance with additional modifications; or 3) the setting is out of compliance. Notification of the analysis will be shared with providers in writing and will identify areas that they must change to come into compliance. Each provider will have the opportunity to provide the State additional information to show they are in compliance. Providers who are not in compliance may request technical assistance from the State but will be required to submit and implement a State approved corrective action plan. Each Office will conduct an on-site review to evaluate the validity of remediation compliance. An appeal process, to be developed, will allow the provider to dispute the HCB Setting's compliance. A disenrollment process of non-compliant providers will be developed and consist of: 1) provider disenrollment as a Medicaid provider; 2) a transition plan for participants; and 3) an appeal mechanism for participants and providers. Implementation of a transition plan will be developed for those needing to transfer to an appropriate HCB Setting. Individuals will be given timely notice and a choice of alternative providers. Transition of each individual will be tracked to ensure successful placement and continuity of services.
The timeline for activities are as followed:
Conduct site visits 5/1/15-10/31/15
Assessment from providers due to OCDD 9/30/15
Analyze Findings from self-assessment and site visits 5/1/15-12/31/15
Post Findings 1/31/16
Submit to CMS as a Final Report 1/31/16
Draft participant survey for public review - Timelines will need to be adjusted based on stakeholder feedback on results of assessments and evaluation of Provider quality framework in order to develop a robust participant survey.
Post on website for public notice - Timelines will need to be adjusted based on stakeholder feedback on results of assessments and evaluation of Provider quality framework in order to develop a robust participant survey.
Circulate to stakeholders - Timelines will need to be adjusted based on stakeholder feedback on results of assessments and evaluation of Provider quality framework in order to develop a robust participant survey.
Distribute participant survey - Timelines will need to be adjusted based on stakeholder feedback on results of assessments and evaluation of Provider quality framework in order to develop a robust participant survey.
Participant survey due to OCDD- Timelines will need to be adjusted based on stakeholder feedback on results of assessments and evaluation of Provider quality framework in order to develop a robust participant survey.
Analyze Findings -Timelines will need to be adjusted based on stakeholder feedback on results of assessments and evaluation of Provider quality framework in order to develop a robust participant survey.
Post Findings -Timelines will need to be adjusted based on stakeholder feedback on results of assessments and evaluation of Provider quality framework in order to develop a robust participant survey.
Submit to CMS as Final Report 1/31/16.

Ensuring Quality:
All certifications, licensing, rules, policy and procedures and other documents have been reviewed by OCDD to ensure compliance with the HCB Setting Rule. The provider enrollment process, provider qualifications, and service definitions are in line with the Setting Rule. All staff associated with the above listed functions will be trained on the new regulations and the Louisiana Statewide Transition Plan. Changes to enhance support of the Settings Rule will continue to be considered and adopted. Louisiana will assess provider compliance through reports, interviews and on-site inspections that will gather information from providers and individuals receiving services. Participant surveys, including the National Core Indicators survey, will ask questions whose specific object is that of obtaining the individual's perception of the Settings Rule. Progress on completion of this Statewide Transition Plan will be monitored at least every three months and will include public posting on the status of the Plan to facilitate public input. Stakeholder engagement and sharing public information will continue through the implementation of the Plan, with the following benchmarks appearing on the website: 1) final copies of the residential and non-residential assessment documents; 2) final copy of the participant survey; and 3) a copy of the Master Plan, updated as needed. Each Office will issue a final report to CMS in March, 2019.

Summary of comments:
During the initial comment period, OCDD received a number of comments/questions through telephone, email, and at public forums. In instances where the focus was on persons that have attended vocational programs for many years there was concern expressed that the person and/or their families may be opposed to looking for work or other activities in the community. Some concerns expressed included individual safety in the community as well as acceptance/willingness of employers to hire the individual's we support. The State's response included that

the person must be offered choice through a person-centered planning process and this area must be explored on a regular basis and is not a one-time discussion. Safety concerns should be addressed as they are now by identifying potential risk and planning potential mitigation strategies through the plan of care. The State has expressed that for all persons their services must be individualized and integrated.
Many stakeholders had questions surrounding the future of prevocational and day habilitation services. Stakeholders were interested in future plans for prevocational and day habilitation settings, specifically whether or not these facilities would be closed. The State's response to these questions is that it is not our intent to close these programs, but there is an expectation that all of these setting will come into compliance with the settings rule. The State will also introduce changes to prevocational services, modifying the service definition for all of our waivers to time limit this service option for 4 years.
Many of the State's vocational providers described their current practices and requested feedback/guidance from the state related to whether their businesses would be considered in compliance. The State has provided guidance to each of these providers related to modifications to policies and/or practices that would bring them into compliance with the CMS rule. In many instances when the service provider has requested guidance, the State has sent a representative to the service provider agency to review and explore ways in which compliance can be met. Discussions have surrounded individualizing each person's experience and offering choice via the person centered plan; process to integrate current programs by getting out into the community or bringing the community into their facilities; and reviewing current employee structure.
Multiple questions/comments were received related to barriers with other state operating agencies that could potentially impact the service provider's ability to successfully implement changes to integrate their programs. The State is committed to working with other state agencies to educate and work closely with those entities to modify rules, regulations, policies, and procedures to comport with the CMS rule.
In response to comments/questions related to the provision of outreach to families, the State has always recognized the need to offer opportunities to meet with individuals and/or their families and educate them related to all activities/changes to services. We will continue to be responsive to our stakeholders and provide outreach opportunities to individuals and/or their families on a regular basis.
In response to comments/questions posed related to inclusion of service providers in the person centered planning process, it is the expectation of the State that all entities involved in planning for the individuals supported in our programs will be responsible for engaging in the person centered planning process to identify and assure that the person's individual choices and preferences are reflected in their plan of care. It is further our expectation that planning is an ongoing process and not a one-time event and that all persons that need to be a part of that process are present and engaged in the development/implementation of the person-centered plan.
Several questions/comments received focused on the provider self –assessment, specifically a timeline for training and receipt of assessment. The State will provide each provider agency with a self-assessment tool to complete and determine whether they are in compliance with the settings rule. Training/Guidance will be provided as to how the assessments are to be completed and the results of the assessments will be posted for the public to access. For those service provider agencies not in compliance a transition plan will be developed by each agency detailing how they will come into compliance with the CMS rule.
Finally, the State received feedback outlining questions/concerns as to whether our transition plan and the process initiated were in compliance with CMS requirements. It further outlined concerns with the State meeting deadlines as posted. In response the State provided detailed information related to the transition process, actions taken to date, future actions, such as, an internal review of deadlines as outlined, and descriptions of the documents posted online for review.

The final Statewide Transition Plan Report will be forwarded CMS no later than March, 2019.

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

## Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   *(Do not complete item A-2)*

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

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

   *(Complete item A-2-a).*

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

Specify the division/unit name:
**The Office for Citizens with Developmental Disabilities**

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

## Appendix A: Waiver Administration and Operation

**2. Oversight of Performance.**

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

b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
The State Medicaid Agency, BHSF, and the operating agency OCDD, have a Memorandum of Understanding (MOU) defining the responsibilities of each. The MOU is to be reviewed yearly and updated as necessary. To ensure compliance with federal regulations governing waivers, BHSF created the Medicaid Program Support and Waivers (MPSW, formerly known as Waiver Compliance Section (WCS)to oversee the administration of all Medicaid waiver programs within Louisiana. Monitoring is completed under the direction of the Medicaid Program Support and Waivers Program Manager.

BHSF and OCDD have a common and concurrent interest in providing Medicaid eligible individuals access to waivers and other identified services through qualified providers, while ensuring the integrity of the Medicaid program is maintained. The interagency agreement requires BHSF and OCDD to:
• meet quarterly to evaluate the waiver program and initiate necessary changes to policy and/or reimbursement rates
• meet quarterly with the Division of Health Economics to review the financial accountability reports for the waiver program

BHSF through MPSW facilitates semi-monthly meetings with OCDD and the Medicaid data contractor to discuss waiver issues and problems. At these meetings, solutions are formed, corrective action agreed upon, and follow-up implemented by OCDD as necessary. In addition, meetings are held at least quarterly with MPSW, the Medicaid Director or Deputy Director, the OCDD Assistant Secretary, and other designated staff to discuss problems, issues, planning, concerns, and any other matters concerning the waiver as necessary. Variance meetings are also held monthly with OCDD, DHH's Division of Health Economics, and MPSW to review financial utilization and expenditure performance of all OCDD' waivers.

BHSF retains oversight of all waiver operations and administrative functions performed by the operating agency. In furtherance of carrying out the interagency agreement and under the authority of BHSF, the following activities occur:
1. Disseminate information concerning the waiver to potential enrollees – Frequent and regular meetings are held between OCDD and MPSW where proposed changes are discussed prior to OCDD developing drafts. Drafts are submitted to MPSW for our input and suggestions. Revisions are made accordingly until a final draft is completed for Medicaid review and approval. As needed, MPSW will participate in training conducted by OCDD when implementing changes with providers. BHSF develops and distributes brochures, flyers, and other informational material regarding available programs to Louisiana citizens. BHSF oversees the website information, as well as communication distribution via Help Lines regarding waiver eligibility and policy administration.
2. Assist individuals in waiver enrollment – BHSF maintains supervision by approving the process for entry of individuals into the waiver through the OCDD regional office and post-linkage procedures carried out by OCDD and the contractors.
3. Manage waiver enrollment against approved limits – BHSF receives bi-weekly reports from the Medicaid data contractor which identify the number of participants receiving services, exiting the waiver, and offered a waiver opportunity. This report is reviewed with OCDD during the bi-weekly meetings. Other reports which are received by both BHSF and OCDD include waiver closure summary reports, admissions summary reports, level of care intake, acute care utilization, and waiver expenditures.
4. Monitor waiver expenditures against approved limits – OCDD is responsible for completing the annual CMS-372 report utilizing MMIS data and submitting it to BHSF for review and approval. Quarterly meetings with BHSF, OCDD, and the Division of Health Economics are held to discuss waiver administration and to review financial participation and budget forecasts in order to determine if any adjustments are needed.
5. Conduct level of care evaluation activities – OCDD is responsible for submitting aggregated reports on level of care assurances to BHSF on a quarterly basis. In addition, the Medicaid data contractor submits reports to BHSF on the number of initial enrollees who meet the required level of care prior to receipt of services and the number of participants who received an annual

redetermination at least annually.
6. Review participant service plans to ensure that all waiver requirements are met – OCDD is responsible for submitting aggregated reports on plan of care assurances to BHSF on an established basis. In addition, the Medicaid data contractor submits reports to BHSF on the number of service plans updated/revised at least annually, number of participants who received all types of services specified in their service plan, and number of participants who received services in the amount, frequency, and duration specified in the service plan.
7. Prior authorize waiver services – BHSF oversees OCDD' exercise of prior authorization activities through reports issued by the Medicaid data contractor. Bi-weekly meetings are held with BHSF, OCDD, and the Medicaid data contractor to discuss any issues relevant to prior authorization. BHSF ensures waiver services are authorized and utilized in conformance to waiver requirements through the annual monitoring conducted during the licensing surveys and random audits of the plans of care. System changes related to claims processing and prior authorization can only be facilitated by BHSF.
8. Determine waiver payment amounts or rates - BHSF determines all waiver payment amounts/rates in collaboration with OCDD, Division of Health Economics, and as necessary the Rate & Audit section.
9. Conduct training and technical assistance concerning waiver requirements – The Medicaid fiscal intermediary conducts annual training related to Medicaid requirements with prior approval from BHSF on all material. BHSF also reviews all OCDD waiver policies and satisfaction survey results as it relates.

BHSF's Health Standards Section conducts all licensing surveys of providers that render waiver services.

Among the numerous reports generated by the Medicaid data contractor and provided to BHSF/MPSW for oversight are the following: number of individuals linked to each support coordination agency by waiver; waiver offers in process but not yet certified; number of recipients assigned to each support coordinator; direct service workers report; number of waiver closures by type; timeliness of annual plans of care; tracking timeliness, accuracy, and approval of plans of care; pre and post authorization report; individuals listed on the Request for Services Registry; waiver offers made and accepted; days from linkage to support coordination agency to plan of care submission and approval; authroized and released amounts for waiver caps; authorized and released amount by procedure codes; and unduplicated waiver counts.

These reports disclose the status of the waiver operation on a day-to-day basis. Reports may reveal such things as LOC determination and whether or not they are being performed timely and appropriately, as defined by policy. Training reports provide information on frequency and attendance. Other reports provide information on waiver utilization. By review of these reports and meetings with the operating agency, BHSF excercises administrative authority by seeking information and solutions on discrpeancies, areas needing improvement, as well as observing areas that are working well in the waiver on a day-to-day basis.

Additionally, MPSW receives monthly Program Integrity reports for aberrant billing practices and enrollment, as well as ongoing reports from Health Standards regarding provider licensing and certification, and annual reports on waiver monitoring.

MPSW reviews the reports from the operating agency, fiscal agent, point of entry contractor, and data contractor to determine if the results indicate areas of non-compliance. MPSW will pursue a series of corrective actions including requiring or conducting additional training and increasing the level of departmental involvement in the decision-making process.

There are several cross agency workgroups which have been formed in order improve the Quality Improvement System within many Medicaid Waivers, including the Residential Opportunities waiver.

The Cross-Waiver Executive Management Team is held monthly with the Medicaid Director, Deputy Medicaid Director, and OCDD Assistant Secretary, MPSW, OCDD and other relevant staff to discuss planning, budgetary matters, compliance issues, technical assistance, and other issues that affect the Medicaid waivers. This group serves to: adopt quality standards and measures for HCBS Waivers; oversee the performance of the HCBS waivers to assure their effectiveness, efficiency, and integration; evaluate performance reports; take action on recommendations from other Cross-Waiver Quality Teams/Workgroups; and trouble shoot critical issues.

The Cross-Waiver Stakeholder Advisory Committee meets twice a year and includes members of MPSW, State Operating Agencies, consumer, providers, and advocates. In these meetings, HCBS quality measures are identified and assessed for updates, performance data is evaluated, and quality improvement initiatives are advised.

The Cross-Waiver Quality Review Team meets every other month and is composed of quality, programmatic & IT representatives from the Program Offices, Medicaid, and DHH IT. This team reports to the Cross-Waiver Executive Management Team. Among other things, the team serves to: integrate waiver polices, review drafted policies and other reports related to HCBS waivers that assure consistency with quality standards; share information regarding best practices; design, generate, and review comparative performance reports; collaborate on joint policy for rules, issues, policies for Support Coordination, Direct Service Providers, and Critical Incident Reporting.

## Appendix A: Waiver Administration and Operation

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

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
The Medicaid data contractor tracks data on plans of care, such as date the initial plan is submitted and approved, date the annual POC is approved, date the POC is received by the regional office, etc.; tracks support coordination, provider services, waiver slots both occupied and vacant, tracks information on time lines, offerings of waiver slots and linkages to support coordination agencies, tracks Waiver certification process; provides prior authorization functions; maintains the Request for Services Registry; issues freedom of choice forms to the participant/family members to select a Support Coordination Agency, collects data from providers, provides notification to providers.

The fiscal/employer agent ensures that participants prior authorized service limits for self-directed services are not exceeded; executes provider agreements on behalf of the Medicaid agency, and processes employer-related payroll and necessary taxes on behalf of Self-Direction participants.

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

## Appendix A: Waiver Administration and Operation

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

● **Not applicable**

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

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

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

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

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

## Appendix A: Waiver Administration and Operation

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

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

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

## Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The Medicaid Contract Monitor for the Medicaid Data Contractor reviews a report listing the activities and deliverables for the previous month. This report includes support coordination linkage, period of time between linkage and service delivery, number of new and closed support coordination linkages and summary statistics. The previous month's billing information is also included in the report so the report and invoice are linked together.

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

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

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

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

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

## Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

i. **Performance Measures**

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

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

***Where possible, include numerator/denominator.***

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

**Performance Measure:**
**A.a.i.1. Number and percentage of policies and provider notices that have been approved by MPSW prior to implementation by the operating agency. Percentage=Number of policies and provider notices approved by MPSW prior to implementation by the operating agency/Total number of policies and provider notices implemented.**

**Data Source** (Select one):
**Program logs**
If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**
**A.a.i.2. Number and percentage of waiver assurance trend and data reports that were submitted timely, as defined by contract/other agreement, by the operating agency/contractor, separated by entity. Percentage = Number of trend and data reports submitted timely by the operating agency and data contractor/Total number of agreed upon waiver assurance trend and data reports due.**

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

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

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

**Performance Measure:**
**A.a.i.3. Number and percentage of waiver offers that were appropriately made, according to policy, to applicants on the Request for Services Registry (RFSR). Percentage = Number of appropriately made offers to applicants on the RFSR /Total number of waiver offers made.**

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

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

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

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ✓ **State Medicaid Agency** | **Weekly** | **100% Review** |
| **Operating Agency** | **Monthly** | ✓ **Less than 100% Review** |
| **Sub-State Entity** | ✓ **Quarterly** | **Representative Sample** Confidence Interval = |
| **Other** Specify: | **Annually** | **Stratified** Describe Group: |
| | **Continuously and Ongoing** | ✓ **Other** Specify: Specific look-behind review of at least 5 offers per quarter |

| | | |
|---|---|---|
| | ☐ **Other**<br>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**<br>Specify:<br>Medicaid data contractor | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**A.a.i.4. Number and percentage of level of care/plan of care/critical incident remediation activities occurring in a timely fashion, defined as 30 days or less, separated by report type. Percentage = number of issues remediated timely / total number of issues identified as requiring remediation.**

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

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

**Performance Measure:**
**A.a.i.5. Number and percentage of waiver participants whose services did not exceed the service limits authorized on their plan of care. Percentage +number of plans for which services did not exceed the service limits specified in the approved plan of care/total number of plans.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Medicaid data contractor data system**

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

**Data Aggregation and Analysis:**

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

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ✓ **Other**<br>Specify:<br>Medicaid data contractor | ✓ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**A.a.i.6. Number and percentage of self-direction participants who report satisfaction with the performance of the fiscal agent. Percentage = number of participants who report satisfaction with the performance of the fiscal agent / total number of participants who responded to the survey.**

**Data Source** (Select one):
**Participant/family observation/opinion**
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**<br>Confidence Interval = |
| ✓ **Other**<br>Specify:<br>Fiscal agent | ✓ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>Fiscal agent | ✓ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

**Performance Measure:**
**A.a.i.7. Number and percentage of complaints addressed by the fiscal/employer agent within 10 business days. Percentage= Number of complaints addressed by the fiscal/employer agent within 10 business days / Total number of complaints received.**

**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**<br>Confidence Interval = |
| ✓ **Other**<br>Specify:<br>Fiscal/employer agent | **Annually** | **Stratified**<br>Describe Group: |
| | ✓ **Continuously and Ongoing** | **Other**<br>Specify: |
| | **Other**<br>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**<br>Specify:<br>Fiscal/employer agent | **Annually** |
| | **Continuously and Ongoing** |
| | **Other**<br>Specify: |

**Performance Measure:**
**A.a.i.8. Number and percentage of reports in which the waiver recipient count was not exceeded, as specified in the waiver application. Percentage = Number of reports in which the waiver recipient count was not exceeded / Total number of reports reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**372 report**

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**
**A.a.i.9. Number and percentage of plans of care in which prior authorizations that were issued correctly, according to policy. Percentage = Number of prior authorizations that were issued correctly / Total number of prior authorizations 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 = |
| ☑ **Other** Specify: Medicaid data contractor | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☑ **Other** Specify: Random review of at least 10 participants plan of care per quarter |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

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

**Performance Measure:**
**A.a.i.10. Number and percentage of recipients residing in provider owned or controlled settings in which the HCB character is maintained. Percentage = Number of recipients residing in a provider owned or controlled setting in which the HCB character is maintained / Total number of recipients residing in provider owned or controlled settings.**

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

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

| | | |
|---|---|---|
| Medicaid Data Contractor | | |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ✓ **State Medicaid Agency** | ☐ **Weekly** |
| ✓ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ✓ **Quarterly** |
| ☐ **Other** Specify: | ☐ **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.
A.a.i.9 is used in conjunction with indicator A.a.i.5, which includes a 100% review

**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.
A variety of mechanisms are employed by MPSW to ensure all issues with the operating agency/contractor's performance are remediated:
1. MPSW meets with contractors and operating agency staff on an as needed basis but no less than quarterly to discuss delegated functions, pending issues, and remediation plans. Individual issues requiring remediation will be referred back to the operating agency and/or contractor for correction. MPSW will monitor to ensure remediation activities are completed to address any identified areas of non-compliance within 30 days of notification. Systemic issues requiring remediation will be identified and discussed at the Cross Waiver (which includes staff from MPSW, OAAS, and OCDD) Review Team Commitee meetings. A plan for remediation and person responsible will be developed for each item identified. Remediation strategies and progress towards correction will be reviewed and documented at the next scheduled meeting.
2. 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.
3. 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** |
| | |

| Responsible Party*(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|
| ☐ Other<br>Specify: | ✓ Annually |
| | ☐ Continuously and Ongoing |
| | ☐ Other<br>Specify: |

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

● No

○ Yes

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

## Appendix B: Participant Access and Eligibility

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

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

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

•

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-l 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 are 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. • 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.

• 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 participant 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 and Hospitals. 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.

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

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

Anyone requesting an appeal has the right to withdraw the appeal request at any time prior to the hearing. The appellant may contact the Division of Administrative Law - 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 participant is referred to another waiver that can accommodate the participant's needs.

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 | 225 |
| Year 2 | 325 |
| Year 3 | 325 |
| Year 4 | 325 |
| Year 5 | 350 |

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 | 220 |
| Year 2 | 320 |
| Year 3 | 325 |
| Year 4 | 325 |
| Year 5 | 350 |

## 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).**

Purpose(s) the State reserves capacity for:

| Purposes |
|---|
| Adults and children in nursing facilities who wish to transition to HCBS based on their Request for Services Registry protected date |
| Children (birth through 18) in nursing facilities requiring high-need rates who wish to transition to HCBS who participate in the MFP |

| Purposes |
|---|
| Persons 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 |
| Persons who need HCBS due to a crisis situation |
| Persons Transitioning from Supports and Services Centers to HCBS |
| Persons voluntarily transitioning from ICFs/DD to HCBS based on their RSFR protected date |
| Persons voluntarily transitioning from ICFs/DD to HCBS through conversion |

## Appendix B: Participant Access and Eligibility

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

**Purpose** *(provide a title or short description to use for lookup):*

Adults and children in nursing facilities who wish to transition to HCBS based on their Request for Services Registry protected date

**Purpose** *(describe):*

Provide ROW opportunity to persons who are qualified for both DD services and for a nursing facility due to their complex medical needs and who are on the Request for Services Registry. The ROW will provide a waiver opportunity for transition into the community.

**Describe how the amount of reserved capacity was determined:**

The amount of the reserved capacity is based on the number of adults and children residing in nursing homes who meet the ICF/DD level of care based on data obtained from the Medicaid Program and who have requested home and community based services.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 15 |
| Year 2 | 20 |
| Year 3 | 10 |
| Year 4 | 15 |
| Year 5 | 20 |

## Appendix B: Participant Access and Eligibility

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

**Purpose** *(provide a title or short description to use for lookup):*

Children (birth through 18) in nursing facilities requiring high-need rates who wish to transition to HCBS who participate in the MFP

**Purpose** *(describe):*

Provide ROW opportunities to children who reside in nursing facilities who are birth through age 18 and are qualified for both DD services and for a nursing facility due to multiple and complex medical needs requiring higher-need nursing facility rates and participate in the MFP. The ROW will provide a waiver opportunity for transition into the community.

**Describe how the amount of reserved capacity was determined:**

The amount of the reserved capacity is based on the number of children identified who reside in nursing facilities and who qualify for the ICF/DD level of care.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 20 |
| Year 2 | 24 |
| Year 3 | 15 |

| Waiver Year | Capacity Reserved | |
|---|---|---|
| Year 4 | 20 | |
| Year 5 | 25 | |

## Appendix B: Participant Access and Eligibility

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

**Purpose** *(provide a title or short description to use for lookup):*

Persons 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

**Purpose** *(describe):*

To ensure OAAS waiver participants who currently have a OCDD Statement of Approval (SOA) receive the most appropriate services and care management under managed care, any individual with intellectual and developmental disabilities (I/DD) who is receiving OAAS Community Choice Wavier (CCW) services will be transitioned to the Residential Options Waiver (ROW)

**Describe how the amount of reserved capacity was determined:**

The amount of reserved capacity was determined by the number of individuals with intellectual and developmental disabilities (I/DD) who are receiving Community Choice and or Adult Day Health Care support via Office of Adult and Aging Services who are expected to transition to the ROW beginning October 1, 2015 and for whom the OCDD services will more appropriately address their needs.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved | |
|---|---|---|
| Year 1 | 0 | |
| Year 2 | 0 | |
| Year 3 | 200 | |
| Year 4 | 55 | |
| Year 5 | 14 | |

## Appendix B: Participant Access and Eligibility

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

**Purpose** *(provide a title or short description to use for lookup):*

Persons who need HCBS due to a crisis situation

**Purpose** *(describe):*

To provide for the emergency health and safety needs of persons in a crisis situation who meet the ICF/DD level of care when waiver services are necessary to avoid institutionalization.

**Describe how the amount of reserved capacity was determined:**

The amount of reserved capacity is based on analysis of emergency need situations involving requests for waiver or ICF/DD services.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved | |
|---|---|---|
| Year 1 | 45 | |
| Year 2 | 96 | |
| Year 3 | 25 | |
| Year 4 | 100 | |
| Year 5 | 115 | |

## Appendix B: Participant Access and Eligibility

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

**Purpose** *(provide a title or short description to use for lookup):*

Persons Transitioning from Supports and Services Centers to HCBS

**Purpose** *(describe):*

ROW opportunities will be available to residents residing at Supports and Service Centers. Residents will have the opportunity to choose to transition from a Supports and Service Center into home and community based services.

**Describe how the amount of reserved capacity was determined:**

The amount of reserved capacity was determined by estimating the number of Supports and Service Center residents who wish to transition to HCBS services.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved | |
|---|---|---|
| Year 1 | 45 | |
| Year 2 | 50 | |
| Year 3 | 15 | |
| Year 4 | 50 | |
| Year 5 | 55 | |

## Appendix B: Participant Access and Eligibility

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

**Purpose** *(provide a title or short description to use for lookup):*

Persons voluntarily transitioning from ICFs/DD to HCBS based on their RSFR protected date

**Purpose** *(describe):*

Provide ROW opportunities to persons residing in ICFs/DD who are on the Request for Services Registry. Providing ROW opportunities to these individuals will assist in reducing the overall number of people residing in ICFs/DD who have expressed an interest in receiving HCBS.

**Describe how the amount of reserved capacity was determined:**

The amount of the reserved capacity is based on the number of persons residing in private ICFs/DD who have expressed an interest in transitioning to home and community based services.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved | |
|---|---|---|
| Year 1 | 75 | |
| Year 2 | 75 | |
| Year 3 | 20 | |
| Year 4 | 25 | |
| Year 5 | 50 | |

## Appendix B: Participant Access and Eligibility

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

**Purpose** *(provide a title or short description to use for lookup):*

Persons voluntarily transitioning from ICFs/DD to HCBS through conversion

**Purpose** *(describe):*

Provide ROW opportunities to persons who meet the ICF/DD level of care and who wish to receive waiver services. This group includes persons whose existing ICF/DD funding/rates can fully fund their transition to a ROW residential setting through voluntary ICF/DD conversion.

**Describe how the amount of reserved capacity was determined:**

The amount of the reserved capacity is based on the statewide stakeholder meetings which have been conducted with ICF/DD residents, residents' families, and providers. These providers have indicated a potential interest in converting their ICFs/DD into ROW opportunities for the residents of the ICF/DD.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 20 |
| Year 2 | 55 |
| Year 3 | 40 |
| Year 4 | 60 |
| Year 5 | 70 |

## 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 MR/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:

- [x] **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**
- [x] **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:*

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 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 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. 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:*

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

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

When the LGE sends an approved Plan of Care to the Medicaid data contractor, the information contains the date of the 90L (date of the physician's 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 waiver applicants who have been determined to meet the ICF/DD level of care prior to waiver certification. Percentage = Number of applicants in the sample who were determined to have met the level of care determination criteria /Number of applicants reviewed in the sample.**

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

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

| | | |
|---|---|---|
| | | |

**Data Aggregation and Analysis:**

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

**Performance Measure:**
**B.a.i.b.1. Number and percentage of waiver participants who received a level of care re-evaluation within 12 months of their initial or annual evaluation. Percentage = Number of waiver participants who received a timely level of care re-evaluation / Total number of waiver participants due for a re-evaluation reviewed in the sample.**

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

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

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

**Data Aggregation and Analysis:**

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

c. ***Sub-assurance: The 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 applicants/participants who's LOC has been completed following state procedures. Percentage = Number of levels of care completed according to state procedures/Total number of waiver partiicpants reviewed.**

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

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

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

**Data Aggregation and Analysis:**

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

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

**b. Methods for Remediation/Fixing Individual Problems**

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

A variety of mechanisms are employed by MPSW to ensure all issues with the operating agency/contractor's performance were remediated:

1. MPSW meets with the contractors and operating agency staff on an as needed basis but no less than quarterly to discuss delegated functions, pending issues, and remediation plans. Individual issues requireming remediation will be referred back to the operating agency and/or contractor for correction. MPSW will monitor to ensure remediation activities were completed to address any identified areas of non-compliance within 30 days of notification. Systemic issues requiring remediation will be identified and discussed at the Cross Waiver (which includes staff from MPSW, OAAS, and OCDD) Review Team Commitee meetings. A plan for remediation and persons responsible will be developed for each identified item. Remediation strategies and progress towards correction will be reviewed and documented at the next scheduled meeting.

2.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.

3. Memorandums are sent from BHSF to OCDD to ensure all necessary leadership is informed of the support actions neede 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):* |
|---|---|
| | |

| **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.