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:**
Supports Waiver

C. **Waiver Number:LA.0453**
Original Base Waiver Number: LA.0453.

D. **Amendment Number:**

E. **Proposed Effective Date:** *(mm/dd/yy)*
01/01/18
Approved Effective Date of Waiver being Amended: 07/01/14

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The Proposed Amendment will implement the 'tiered' waiver process which will establish one Request for Services Registry for all OCDD Waivers and the participant will receive a waiver opportunity based on the needs based assessment and person-centered planning process.
This amendment will eliminate the two "reserved capacity" groups from the SW and entry into the waiver will come from two priority groups, which is the same across OCDD adult waivers; Pinecrest/CEAs and individuals with the highest urgency of need and earliest registry date who are on the Request for Services Registry.
This Amendment aligns the Performance indicators with the previously approved Performance Indicators in the other OCDD waivers.
This Amendment aligns with the other approved OCDD waivers which allows for Support Coordinators to complete the annual Level of Care redetermination.
This Amendment aligns with the other OCDD waivers to accept the physician's designee or nurse practitioner signature on the 90L form.
A name change from Department of Health and Hospitals (DHH) to Louisiana Department of Health (LDH) to align with the state amendment.
This amendment allows for a medically needy spend down.
Added reference for the "Guidelines for Support Planning" as framework for all activities related to planning.
This amendment aligned the Appendix F with the current law.
This amendment aligned the Appendix G with the current process.
This amendment aligned Appendix H with the current process.
This amendment increased the number served in years 4 and 5 of this waiver.

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:
Aligning QIS with the other OCDD waivers. Implements one Request for Services Registry. Allows for a medically needy spend down. Allows for Support Coordination to complete the annual Level of Care Redetermination. Allows for a physician's designee or nurse practitioner to sign the 90L form. Name change for Department of Health and Hospitals to Louisiana Department of Health. Increase the number to be served in years 4 and 5 of the waiver. Aligns language in Appendices F, G, and H

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*):
Supports Waiver
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**

Original Base Waiver Number: LA.0453
Draft ID: LA.006.02.02
D. **Type of Waiver** *(select only one)*:
Regular Waiver
E. **Proposed Effective Date of Waiver being Amended: 07/01/14**
Approved Effective Date of Waiver being Amended: 07/01/14

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 goals of the Supports Waiver are as follows:

• To create options and provide meaningful opportunities that enhance the lives of men and women with developmental disabilities through vocational and community inclusion.

• To promote independence for individuals with a developmental disability who are age 18 or older while ensuring health and welfare through a system of participant safeguards.

• To increase high school to community transition resources by offering supports and services to those 18 years and older.

The objectives of the Supports Waiver are as follows:

• To allow the participant choice in selecting providers and support coordination agencies through Freedom of Choice forms;

• To develop an individualilzed plan of care that embraces the participant's self-determination and is responsive to the participant's specific needs and preferences;

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

• Offer an alternative to institutionalization 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 in exercising their rights and sharing responsibility for their programs regardless of the method of service delivery;

• Utilize personal outcome interviews and standardized assessment tools to assist in the creation of participant-centered service plans that reflect participant's needs and preferences; AND

• To allow the participant the choice between institutional care and home and community-based services.

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

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

Services are accessed through a single point of entry in the LGE. When criteria are met, individual's names are placed on the Request for Services Registry until an offer for services is made. All waiver participants choose their Support Coordination and Direct Service Provider

Agencies through the Freedom of Choice process. A needs based assessment and person-centered planning process is utilized during the initial phase to determine the OCDD waiver that is offered. The initial plan of care (POC) is developed during this person-centered planning process and approved by the LGE. Annual reassessments may be approved by the Case Management agency supervisor as allowed by OCDD policy. Case Management Agencies are designated as Support Coordination agencies throughout this application. All services must be prior authorized and delivered in accordance with the approved plan of care. Prior authorization is completed by a contracted data source with LDH. The average participant's expenditures for all waiver services shall not exceed the average Medicaid expenditures for ICF/DD services.

3. Components of the Waiver Request

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

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

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

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

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

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

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level (s) of care specified in Item I.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:
OCDD has engaged in a variety of focused system change activities over the past three years, many of which resulted in incremental improvements in rebalancing, quality, and community services availability. Systems Transformation initiatives were implemented with a goal of serving more people in home and community-based services (HCBS), achieving cost effectiveness in HCBS versus institutional options, reducing institutional reliance in both private and public settings, providing access to appropriate services based on need, and increasing appropriate utilization of natural and community supports. Large-scale stakeholder engagement regarding Systems Transformation began in 2012 and has continued. A core stakeholder workgroup was established which includes individuals / families with I/DD, advocacy organizations, and provider organizations, to inform the decision-making process regarding System Transformation efforts. OCDD has also met with a variety of other stakeholders to inform the public about System Transformation efforts and to solicit feedback. The following table illustrates meeting dates with stakeholder groups.

Stakeholder Group Meeting Dates
Core Stakeholder Group 8/23/13, 9/27/13, 10/25/13, 11/22/13, 12/13/13, 1/10/14, 2/10/14, 2/28/14, 3/14/14, 3/28/14, 4/25/14, 5/30/14, 6/27/14, 8/22/14, 1/30/15, 2/26/1, 3/26/15, 4/28/15, 4/27/16, 5/9/16, 6/7/16, 7/12/16, 8/2/16, 10/4/16
Large Stakeholder Meetings 2/10/12, 10/31/12, 11/8/12, 7/19/13, 11/21/13, 12/16/13, 3/31/14, 6/24/14, 9/10/14, 4/28/15
Regional Meetings 11/8/12, 11/21/13, 12/19/13, 1/16/14, 2/20/14, 3/20/14, 5/15/14

Based on feedback from these external stakeholder groups, collaboration with internal LDH stakeholders, and research on best practices, OCDD is proposing to move to a tiered system for provision of Home and Community Based waiver services. Two major initiatives have been identified through this collaborative partnership, the Request for Services Registry prioritization and the Tiered Waiver design. It is our belief that these initiatives will have a significant positive impact on the OCDD service delivery system. These initiatives have been fully vetted by OCDD and LDH and are included in the overall strategic planning for the Department.

The SW Rule Notice of Intent which reflects new entrance language is currently being routed within LDH and is expected to be published by September 20, 2017 in the Louisiana Register for public comment.

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: Brian

First Name: Bennett

Title: Section Chief

Agency: Bureau of Health Services Financing

Address: 628 North Fourth Street

Address 2: P.O. Box 91030

City: Baton Rouge

State: Louisiana

Zip: 70821-9030

Phone: (225) 342-6234 **Ext:** ☐ **TTY**

Fax: (225) 342-9168

E-mail: Brian.Bennett@la.gov

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

Last Name: Thomas

First Name: Mark A.

Title: Assistant Secretary

Agency: Office for Citizens with Developmental Disabilities

Address: 628 North Fourth Street

Address 2: P. O. Box 3117-Bin # 21

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:

In years 4 and 5, we are increasing the number from 2050 to 2150 and 2250 respectively. There is an anticipated increase in the number of individuals that will be served in the SW as we move into a one registry and entrance into the waiver is based on a needs based assessment and person centered planning process rather than first come first served.

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):

The Louisiana's Statewide Transition Plan received initial approval on March 3, 2017. The following areas have been identified as areas that need to be addressed to achieve final approval:
• Complete comprehensive site-specific assessments of all home and community based settings, implement necessary strategies for validating the assessment results, and include the outcomes of these activities within the STP
• Draft remediation strategies and a corresponding timeline that will resolve issues that the site-specific settings assessment process and subsequent validation strategies identified by the end of the home and community based settings rule transition period
• Outline a detailed plan for identifying settings that are presumed to have institutional characteristics, including qualities that isolate HCBS beneficiaries, as well as the proposed process for evaluating these settings and preparing for submission to CMS for review under Heightened Scrutiny
• Develop a process for communicating with beneficiaries that are currently receiving services in settings that the state has determined cannot or will not come into compliance with the home and community based settings rule; and
• Establish ongoing monitoring and quality assurance processes that will ensure all settings providing HCBS continue to remain fully compliant with the rule in the future.

Stakeholder Engagement
Initial stakeholder engagement/communications noted on the initial plan. Since the submission of the State-wide transition plan-OCDD has engaged in the following:
• Representative from OCDD conducted onsite meeting with Lafayette ARC on 3/11/2015 and continues to provide assistance as needed via email correspondence.
• Onsite visit with Assumption ARC on 3/12/2015 to evaluate and provide assistance with meeting compliance with rule. On April 12, 2015-pilot/discussion on completing non-residential assessment.
• OCDD updated partner agencies/stakeholders about transition plan on 3/27/2015 (Work Pays Meeting)
• Memorandum of Understanding Meeting held with Louisiana Rehabilitation Services on 4/20/2015 and 5/28/2015. Next meeting scheduled for 7/16/2015
• Onsite visit with Rapides ARC on 5/18/2015
• Round table employment meeting in New Orleans with employment providers and LGE office to discuss strategies for compliance with settings rule/employment initiatives on 6/2/2015
• Technical assistance phone conference with St. Mary ARC on 6/10/2015
• Presentation at Provider Quarterly meeting related to employment initiatives and compliance with settings rule in Lafayette on 6/25/2015
• Technical assistance onsite and electronic correspondence with Evangeline ARC 2/2015-present
• OCDD will be scheduling Round Table discussions with every LGE and employment provider in their area. This schedule should be available by 9/1/2015
9/30/15 quarterly update:
OCDD has engaged in the following:
• Additional feedback internally received related to the transition plan process/documents. Modifications made to the documents based on this feedback. Final assessments posted online 8/10/15
• Notifications sent to service providers, support coordination agencies, and LGE offices clarifying the process as well as identifying where information can be found online (8/2015)
• Roundtable meetings with vocational service providers, LRS and LGE offices held: Monroe (7/16/15), Florida Parishes (8/11/15), Shreveport (8/13/15), Lake Charles (8/26/15) and Baton Rouge (9/15/2015). Additional meetings are being scheduled
• Met with LRS, Bossier Parish Community College and LGE office to discuss referral process and the program offered at the community college to prepare people for Supported Employment. Internal discussion/consideration being given to establishing a partnership with the programs at the community colleges and the prevocational programs to consider options for job readiness training.
• Presented at employment summit hosted by LRS on 8/28/15
• Information/updates provided at the local AAIDD Conference held September 15-18th, 2015 related to the transition process
• Multiple phone calls and email communications with various service providers across the state to answer questions about the provider self-assessment process and provision of technical assistance as needed. Additional information/updates related to public comment to be provided with this update
12/31/15 quarterly update:
• 10/6/2015—Employment Roundtable in Lafayette
• 10/7/215—Employment Roundtable in Region 3
• 10/8/2015—OCDD staff attended opening of Options new program in Hammond. This is where they rolled out their "volunteer" program and their "arts" program in the community-it was held at the Theatre in Hammond
• 10/15/15-Alexandria Employment Roundtable

• 11/16/2015-Received questions from a vocational provider group regarding changes
• 11/17/15-Visit to LADD and CARC in Region 6
• 11/24/2015-Phone call with WARC in region 8 and the LGE office to answer questions regarding changes to waiver application
• 11/30/2015-SW training with providers to discuss the changes being made to SW which are moving us toward compliance with settings rule
• 12/3-4/2015-Attended LA APSE conference to learn more about WIOA changes
• 12/11/15-Meeting with JPHSA (LGE office) regarding pairing with them to complete validation visit and assist selected provider with completing a transition plan to come into compliance
3/31/2016 quarterly update:
• 1/12/16-Meeting with LGE offices about provider self-assessment process and their role. Addressed follow up action for those providers that have not submitted information to the LGE office.
• 1/25-1/26 Technical Assistance with providers (West Carol ARC and Precision Caregivers)
• 1/20-Lake Charles employment roundtable on transitioning to HCBS compliance
• 2/17-Refresher training with LGEs on their role in the provider validation process
• 2/24-Refresher training for providers related to changes made to the Supports Waiver
• 2/26-Meeting with JPHSA/MHSD to discuss validation visits
• 2/29-Meeting with family stakeholder group to discuss/develop participant experience survey
• 3/3-Meeting with AAHSD to discuss validation visits
• 3/8-CAHSD quarterly provider meeting to discuss HCBS final rule and Supports Waiver changes
• 3/15-Meeting with JPHSA/MHSD to review each element on the provider assessment and validation tool
• 3/16-Conducted site visit with AAHSD of Ageless Day Program
• 3/17-Meeting with IMCAL to review each element on the provider assessment and validation tool
• 3/17-Phone conference with CLHSD to review elements on the provider assessment and validation tool.
6/30/16 quarterly update:
• 4/7/16-State Office assisted Central Louisiana Human Services District (region 6 local office) with completing site visit at a service provider day program.
• Technical assistance provided to Florida Parishes Human Services Authority (region 9 local office) regarding validation visits.
• 4/11/16-State Office assisted South Central Louisiana Human Services (region 3 local office) with completing site visit as service provider day program
• 4/15/16-Coordinated Social Security Presentation/broadcast with the CWICs
• 4/20/16-State Office assisted South Central Louisiana Human Services (region 3 local office) with completing site visit at service provider day program
• 4/19, 4/25, and 5/16-Stakeholder workgroup regarding person centered planning and format options.
• 4/26/16-Presentation with Families Helping Families in Jefferson Parish about CMS rule/changes
• 4/27/16-HCBS quarterly planning progress meeting
• 5/3/16-Meeting with Support Coordination Alliance regarding Individual Experience Survey
• 5/3/16-State Office assisted Florida Parishes Human Services Authority (region 9 local office) with completing site visit for day program service provider.
• 5/10-5/12-State Office assisted Northwest Louisiana Human Services District (region 7 local office) with completing site validation visits for day program providers.
• 5/16/16-State Office assisted Florida Parishes Human Services Authority (region 9 local office) with completing site visit with day program service provider.
• 6/8/16-State Office assisted Capital Area Human Services (region 2 local office) with completing site visit with day program service provider
• 5/24/16-Work Pays meeting
• 5/27/16-5/30/16-State Office assisted Northeast Human Service Authority (region 8 local office) with completing site visits for multiple day program and residential service provider agencies.
• 6/14/16-Update provided regarding STP at a meeting with the Louisiana Council of Executives.
• 6/22/16-Update provided regarding STP for DD Council report
• Presentation at South Central Louisiana Human Services Authority quarterly provider meeting regarding STP progress.
9/30/2016 quarterly update
• OCDD has begun holding monthly provider calls. Invited to participate in these meetings are all service providers, support coordination agencies, and the LGE offices. Agenda items are determined based on feedback from stakeholders as well as areas that OCDD needs to provide updates on. Questions are submitted via email prior to and post meeting. OCDD responds to these questions and posts responses after the meeting. The Statewide Transition Plan was included on the agenda for both the 7/7/16 meeting and the 9/1/16 meeting. OCDD provided an overview of progress on revisions, when stakeholders could anticipate posting of document for review, and responded to questions received prior to calls. See stakeholder question and responses for additional information regarding this area.
• 7/20/2016-presented updates at the DD Council meeting with a focus around employment. Presented overview of the regulation and Louisiana's approach to evaluating compliance and progress in terms of revision to STP and process to come into compliance. Present for this meeting were advocates, self-advocates, family members, provider representatives, and OCDD staff.
• ARC of Louisiana Council of Execs meeting to discuss employment, day habilitation, and prevocational services and impact of CMS rule on those programs
• Meetings with potential members of State Use Program
• AAIDD conference presentation on CMS rule
• Meeting with LRS – updates on WIOA
12/31/16 quarterly update
• 10/6-10/7/2016—Provided updates at the State Independent Living Council Quarterly meeting
• 10/19/16-Met with provider representative to discuss the HCBS regulations. Answered questions and provide interpretation related to understanding of the regulation
• 10/21/16-Assistant Secretary of OCDD provided updates and identified OCDD's expectations related to the rule
• 10/25, 10/26, 10/31/2016—Participated in job fairs for National Disability Employment Awareness Month (NDEAM)

• 11/14-Onsite technical assistance with residential provider
• 11/15-Assistant Secretary of OCDD presented on OCDD's vision related to employment and alignment with regulation at the LA-APSE Employment Symposium
• 11/17/16-State Use Council meeting
• 12/2/16-Technical Assistance visit with LARC
• 12/6/16-State Use Council meeting
3/31/2017 quarterly update
• Meeting on 1/10/2017 with leadership at LARC to review some of the strategies that they are implementing to come into compliance with the rule.
• Attended provider meeting in the SCHSA on 1/11/17 to provide an update on the HCBS transition plan.
• Provided Updates on 1/18/17 related to the HCBS transition plan to the DD Council Employment Committee.
• 1/19 Validation visit-Baton Rouge-Natural Embraces
• 1/24 Validation visit-Baton Rouge-Omni House
• 1/25 Validation visit-Baton Rouge-Bethesda Adult Day Program
• 1/31 Validation visit Baton Rouge-A Step Forward
• 2/1 Validation visit Baton Rouge-Iberville ARC
• 2/7-2/8-Rosemary from Central office provided technical assistance to the LGE office related to the Service provider transition plan.
• 2/9-2/10-Central Office conducted validation visits in Shreveport area (Hap House, Care Services, and Community Angels)
• 2/15-Intenal workgroup discussed possible action items related to employment
• 2/16- CO representative attended Employment First workgroup
• 2/17-Attended Work Pays workgroup
• 2/20-Represenatatives attended State Use Council meeting
• 3/6 and 3/7 employment sub-committee meeting
• 3/8-attended region 6 quarterly provider meeting to provide updates related to HCBS
• 3/18-Governor's Advisory Council on Disability Affairs meeting
• 3/22-Technical Assistance call with G.B. Cooley in Monroe related to developing transition plan to come into compliance with HCBS rule.
• 3/22-employment sub-committee meeting
• 3/23-Employment first workgroup meeting
• 3/30/17 provider validation visit
6/30/2017 quarterly update:
• Participated in Employment First Workgroup meeting on 4/28/17
• Employment First Workshop 5/25/17
• Conference conducted with LGEs on 5/30/17 to discuss CMS extension of timeframe to come into compliance with the rule. At this time, OCDD is planning to extend by 1 year (compliance by 2020)
• Provider meeting conducted on Thursday, 6/1/17 to present information regarding CMS extension to come into compliance with regulation and OCDD's intent to extend by only 1 year versus full 3 years.
• 6/6/17-Employment First Workgroup meeting
• 6/8/17-OCDD held lunch and learn to for LGE offices, SC agencies, and providers with a focus on employment.

OCDD will continue to provide technical assistance to all service provider agencies as requested (will partner with LGE offices where appropriate)
LDH Interagency STP Activities
• Ongoing quarterly meetings with MPSW Section
• OCDD updated partner agencies/stakeholders about transition plan on 3//27/15 (Work Pays meeting)
• 9/23/15—Work Pays Meeting—updated partner agencies/stakeholder about transition plan and employment initiatives
• Memorandum of Understanding meeting held with Louisiana Rehabilitation Services (LRS) on 4/20/15 and 5/28/15.
o Meeting held on 7/16/15-working on draft MOU
o 9/10/15-OCDD met with LRS, OBH and Medicaid to make final edits to draft MOU. Next steps related to MOU are to have each agencies legal department review the document.
• DHH, with representation from OAAS, OCDD, OBH and Medicaid attended the Community Provider Association Legislative and Public Policy Conference on 7/8/15. Representatives from each program office sat on a panel for the HCBS Settings Rule, provided updates on their transition plans and participated in Q&A session with providers.
• OCDD also meets and provides updates regarding STP to groups such as the DD Council, Provider quarterly meetings, SC/LGE quarterly meetings, SILC, and other identified groups as appropriate.
12/31/2015 quarterly update:
• 10/13/2015—Presented information and answered questions regarding the HCBS rule changes to the Executives of the ARC quarterly meeting
• 10/27/2015-State Use Council meeting discussing changes being made to the workshops and integration of rule from CMS and how it will affect the program
• 11/30/2015-Finalizing draft MOU with LRS and OBH
• 12/2/2015-LC Vocational Provider Meeting to answer questions along with LRS
• The STP workgroup met on 11/13; 11/20; 12/1; 12/4; 12/7; 12/11; and 12/16 to discuss responses to CMS and revise the STP to meet CMS requirements.
• 12/18-Updates regarding transition plan and status given to the Provider Association Group
3/31/2016 quarterly update:
• 1/29-Louisiana Rehabilitation Council Meeting presentation. Mark Thomas presented initiatives, HCBS, and working with WIOA
• 2/22-2/23-State Independent Living Council Quarterly Meeting
• Based on input/feedback from providers – OCDD updated the HCBS website to better organize and facilitate ease of use for those persons accessing it. New website went live on 2/24/16. The following link goes to the new website: http://new.dhh.louisiana.gov/index.cfm/page/2313

• STP workgroup met on 2/4/16 and 3/1, and 3/7—meetings on 3/1 and 3/7 were to discuss response to CMS related to milestones
• 3/4-Work Pays/APSE quarterly meeting
• 3/21-Updates regarding transition plan and status given to the Provider Association Group.
6/30/16 quarterly update:
• 4/4/16-OCDD met internally to discuss Individual Experience Survey.
• 4/27/16-HCBS quarterly planning progress meeting
• 5/5/16-OCDD met internally to discuss validation visit progress.
• 5/9/16-STP cross office workgroup met to discuss and plan for STP resubmission
• 5/10/16-STP cross office workgroup met to discuss systemic assessment with consultant and determine next steps in terms of formatting information for resubmission with STP
• 6/7/16, 6/14, 6/16 and 6/20/16 -OCDD and Medicaid meetings to discuss SW renewal-discussions including incorporation of language associated with HCBS rule.
• 6/22/16 and 6/27/16-OCDD met internally to discuss changes to be included in NOW renewal
• 6/23/16-STP workgroup met with consultant to prep for phone conference with CMS -TA call related to addressing all areas to receive initial approval on STP
• 6/24/16-TA call with CMS team regarding resubmission of STP
9/30/2016 quarterly update:
• Cross office workgroup met on the following dates to address feedback and revisions needed to the STP: 7/13, 7/20/16, 7/27/16, 8/3/16, 8/10/16, 8/31/16, 9/6/16 and 9/7/16
3/31/17 quarterly update:
• Feedback received from CMS related to transition plan on 1/13/17. Cross office workgroup met on 1/18/17 to discuss feedback received and to begin work on addressing issues identified. Scheduled a call with CMS to discuss feedback on 2/3/17.
• Cross office group met on 1/26/17 to discuss summary of information that Suzanne pulled together. Identified specific questions to discuss with CMS.
• Call with CMS on 2/3/17-to discuss areas of concern. Based on information received from CMS both in writing and by phone OCDD updated systemic assessment crosswalk, located additional information to support OCDD's public comment process, and submitted all information to Suzanne.
• 2/19/17-Cross agency meeting to discuss adding HCBS language to the general provision section of the waiver rule.
6/30/17 quarterly update:
Interagency Workgroup met to discuss milestone template received from CMS and discuss actions needed to update/revise STP to get final approval on STP on 6/19/17 and 6/26/17Systemic Assessments
The Office for Citizens with Developmental Disabilities (OCDD) is in the process of revising rules/policies/regulations as identified in the Systemic Assessment. OCDD plans to have this completed by December 2017. As modifications/changes made information will be posted for public comment.

Provider Self-Assessments and Site Visits
OCDD and the Local Governmental Entities (LGEs) completed site specific site visits to validate the provider self-assessments. OCDD in partnership with the LGE offices (Local Governing Entities) is in process of working with service providers to complete transition plans to bring services/settings into compliance. OCDD is actively working to consolidate the data and analyze the findings from the site-specific visits to compile a report reflecting the outcome of these visits. As part of this process, settings that require heightened scrutiny will be identified and a process will be established to address these settings.
Individual Experience Survey
A participant survey was developed to measure satisfaction and the participant's overall experiences as they relate to the HCBS Settings Rule. Information collected will be used to validate information reported by provider agencies via self-assessments and site visits. Self-advocates, family members, etc. provided input in the development of the survey. The survey was posted online for public comment and modifications were incorporated into the survey based on the comments. Training was provided on the participant survey May 25, 2016 – May 31, 2016 and the survey was then distributed on June 1, 2016. Participant surveys will be completed in two phases: Phase 1 was completed July 25, 2016 and Phase 2 will be completed by December 31, 2016. OCDD is actively working to consolidate the data and analyze the findings from the individual experience survey. Throughout the process providers that are identified as out of compliance with the regulation will be asked to complete a transition plan to come into compliance with the regulation.
The state assures that the settings transition plan included with this waiver renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State 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.

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:

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

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

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

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

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

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

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

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

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

6. Prior authorization of waiver services - To ensure that payments are accurate for the services rendered OCDD monitors and oversees the requirements of the provider through the prior authorization process and the approved plan of care (POC). BHSF oversees OCDD's exercise of prior authorization activities through reports issued by the Medicaid data contractor and through monthly MPSW/OCDD/HCBS Data Contactor Meetings. System changes related to claims processing and prior authorization can only be facilitated by BHSF. OCDD formally presents service plan performance measure findings/remediation actions to MPSW quarterly via the Medicaid HCBS Oversight Committee as described in Appendix D: QIS sub-assurance c.
7. Utilization management – Reports are generated quarterly from the Medicaid data contractor which include: number of participants who received all types of services specified in their service plan and number of participants who received services in the amount, frequency, and duration specified in the service plan. OCDD reviews these reports for trends and patterns of under-utilization of services. OCDD formally presents service plan performance measure findings/remediation actions to MPSW quarterly via the Medicaid HCBS Oversight Committee as described in Appendix D: QIS sub-assurance d.
8. Establishment of a statewide rate methodology - BHSF determines all waiver payment amounts/rates in collaboration with OCDD, Division of Health Economics, and as necessary the Rate & Audit section. MPSW monitors adherence to the rate methodology as described in Appendix 1 QIS.

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

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

Appendix A: Waiver Administration and Operation

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

(●) **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
Medicaid Data/Prior Authorization Contractor - The Medicaid data contractor compiles and aggregates data on plans of care, such as date the initial plan is submitted and approved, date the annual POC is approved, and date the POC is received by the regional office. The Medicaid data contractor also compiles and aggregates data on support coordination, provider services, waiver slots (both occupied and vacant); compiles and aggregates information on time lines, offerings of waiver slots and linkages to support coordination agencies; compiles and aggregates data on the Waiver certification process; provides prior authorization functions; maintains the Request for Services Registry(RFSR); issues freedom of choice forms to the participant/family members to allow selection of a Support Coordination Agency; collects data from providers and provides various notifications to providers upon direction of OCDD or BHSF.

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

( ) **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:
The Louisiana Department of Health (LDH) Bureau of Health Services Financing (BHSF), with input from the operating agency, is responsible for assessing the performance of the Medicaid Data/Prior Authorization Contractor and Provider Enrollment Contractor.

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:
•Medicaid Data/Prior Authorization Contractor - The Medicaid contract monitor for the Medicaid Data/Prior Authorization Contractor reviews monthly a report tracking volume and timelines for contract activities and deliverables in the previous month. This report includes support coordination linkages, period of time between linkage and service delivery, number of new and closed support coordination linkages, and other summary statistics. The previous months billing information is also included in the report so that 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, meets monthly with contractor to review performance. The data contractor also submits data files quarterly which are reviewed and archived by the contract monitor. If there is substandard performance, MPSW will require a corrective action plan and will monitor implementation.

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

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			

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
	☑	☑	☑
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 performance measure reports which were received on time and complete with operating agency analysis and remediation activities. Percentage = Number of performance measure reports which were received on time and complete with operating agency analysis and remediation activities / Total number of performance measure reports due

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

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

threshold. Percentage = Number of Quality Improvement Projects (QIPs) initiated and submitted to the MPSW Section within three months of findings below the 86% threshold / Total number of QIPs initiated and submitted to MPSW

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

	☐ Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
A.a.i.7. Number and percent of unduplicated participants offered a waiver slot where the number of available slots are less than or equal to those offered. Percentage = Number of unduplicated participants offered a waiver slot / Total number of available slots

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

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

☑ **Other** Specify: Medicaid Data Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

		☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Medicaid Data Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **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.a.i.1 – A.a.i.6
Aggregated data collected for Performance Measures A.a.i.1 – A.a.i.6 are reviewed and analyzed quarterly by via the Medicaid HCBS Oversight Committee. When remediation is indicated, the Committee discusses appropriate remediation activities to resolve identified compliance issues and address systemic improvements when indicated. To achieve this end, MPSW provides technical assistance, guidance, and support to the operating agency staff. Committee minutes document remediation actions and results of these actions are presented at subsequent meetings to verify effectiveness.

The Medicaid HCBS Oversight Committee meets at least quarterly with the specific purpose to ensure proper oversight of the OAAS and OCDD operated HCBS Medicaid programs. Goals are to review current performance reports, determine need for new activities concerning quality and oversight in waiver programs and ensure adequate remediation enforcement. Quality recommendations or issues which cannot be resolved at this level are placed on the agenda of the BHSF/Program Offices HCBS Executive Committee. Members of the Medicaid HCBS Oversight Committee include HCBS quality management staff from MPSW and OCDD and it is chaired by the MPSW Section Chief or designee.

A.a.i.7

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

A.a.i.8

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

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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	18		☑
	☑	Developmental Disability	18		☑
	☑	Intellectual Disability	18		☑
☐ 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 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:

Appendix B: Participant Access and Eligibility

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

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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:

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:

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	2500
Year 2	2500

Waiver Year	Unduplicated Number of Participants
Year 3	2500
Year 4	2500
Year 5	2500

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	2050
Year 2	2050
Year 3	2050
Year 4	2150
Year 5	2250

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. **Allocation of Waiver Capacity.**

Select one:

◉ **Waiver capacity is allocated/managed on a statewide basis.**

○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

• In accordance with Title 50 PUBLIC HEALTH- MEDICAL ASSISTANCE Part XXI. Home and Community Based Services Waivers, Subpart 5. Supports Waiver.

The Intellectual/Developmental Disabilities Requests for Services Registry (IDD RFSR), hereafter referred to as "the registry," is the list that documents and maintains the person's name and protected request date for waiver services. A person's protected request date for any OCDD waiver is the date of the first face-to-face interview in which he/she applied for waiver services and is determined eligible for developmental disabilities services by the entry unit.

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

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

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

2. Individuals on the registry who have the highest level of need and the earliest registry date shall be notified in writing when a funded OCDD waiver opportunity is available and that he/she is next in line to be evaluated for a possible waiver assignment.

Once an eligible individual is identified, the case management agency will conduct person centered discovery activities and two needs-based assessments. SW opportunities will be offered to individuals age 18 or older, or their alternates age 18 or older, based on the results of the two needs based assessments and the person centered planning discussion. The plan of care, with the needs-based assessments will be validated by the LGE through the required in-home visit for all initial waiver recipients. Individuals who disagree with the OCDD waiver offered as a result of the needs-based assessments and person centered planning process may appeal the waiver offer decision through the OCDD appeals process.

Funded waiver opportunities will only be allocated to individuals who successfully complete the financial eligibility and medical certification eligibility process required for waiver certification.

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

Medicaid's data contractor has responsibility for maintenance of the IDD Request for Services Registry (the registry). Offers are made for persons on the registry by the Medicaid data contractor based upon the above stated policies and procedures and as written in B-3-f. Also, BHSF/MPSW has oversight of the data contractor's role in maintaining the registry according to policy. In addition, monthly meetings are held between the Medicaid data

contractor, OCDD, and BHSF/MPSW to review and to assure adherence to these regulations along with equitably and fairness in allocations and distributions of waiver opportunities.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (•) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (•) **No**
   - ( ) **Yes**

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

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

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

  Select one:

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

  Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- ☑ **A special income level equal to:**

Select one:

- ◉ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

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

Specify dollar amount:

- ☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- ☐ **Medically needy without 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/Development Disability and other incurred expenses to reduce an individual's income.

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

◉ **The following standard included under the State plan**

Select one:

○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
◉ **The special income level for institutionalized persons**

(*select one*):

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

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

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

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

  Specify:

  [ ]
- ( ) **The following dollar amount**

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

  Specify:

  [ ]
- ( ) **Other**

  Specify:

  [ ]

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

- (●) **Not Applicable (see instructions)**
- ( ) **SSI standard**
- ( ) **Optional State supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ( ) **The amount is determined using the following formula:**

  Specify:

  [ ]

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

- (●) **Not Applicable (see instructions)**
- ( ) **AFDC need standard**
- ( ) **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

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

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

Select one:

◉ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

○ **The State does not establish reasonable limits.**

○ **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

  Select one:

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

    (*select one*):

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

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

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

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

    Specify:

    [ ]
- ( ) **The following dollar amount**

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

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

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

○ **SSI standard**

○ **Optional State supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

Specify:

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

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ( ) **SSI standard**
- ( ) **Optional State supplement standard**
- ( ) **Medically needy income standard**
- (●) **The special income level for institutionalized persons**
- ( ) **A percentage of the Federal poverty level**

Specify percentage:

○ **The following dollar amount:**

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

○ **The following formula is used to determine the needs allowance:**

Specify formula:

○ **Other**

Specify:

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

Select one:

◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

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

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

Select one:

◉ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

○ **The State does not establish reasonable limits.**

○ **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the

provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

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

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

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

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

Specify the entity:

- ( ) **Other**

Specify:

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

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

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

•The level of care criteria, in accordance with Louisiana Revised Statue Chapter 4-A, Title 28:451.2 (R.S. 28:380.2) repealed by legislation of Act 128 effective June 22, 2005) is as follows:
RS 28:451.2. Definitions:
(12) Developmental Disability means either:
(a) A severe chronic disability of a person that:
(i) Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments.

(ii) Is manifested before the person reaches age twenty-two.
(iii) Is likely to continue indefinitely.
(iv) Results in substantial functional limitations in three or more of the following areas of major life activity:
(aa) Self-care
(bb) Receptive and expressive language.
(cc) Learning.
(dd) Mobility.
(ee) Self-direction.
(ff) Capacity for independent living.
(gg) Economic self-sufficiency.
(v) Is not attributed solely to mental illness.
(vi) Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

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

The Office for Citizens with Developmental Disabilities (OCDD) form 90-L is used to determine the ICF/DD Level of Care. The individual's primary care physician /designee (nurse practitioner or physician's assistant who practices under the supervision and license of a board certified physician) must complete, sign and date the 90-L for initial determination of LOC. The 90-L is used in conjunction with the Statement of Approval (SOA) to establish a level of care criteria and to assist with completion of the Plan of Care. SOA is a notification to an individual who has requested waiver services that it has been determined by the LGE that they meet the developmental disability criteria (Developmental Disability Law- La. R.S. 28:451) for participation in programs administered by OCDD and that they have been placed on the Request for Services Registry for waiver services with their protected date of request. The 90-L, SOA and initial plan of care documents are submitted by the Support Coordination Agency to the LGE staff for review to assure that the applicant/participant meets/continues to meet the level of care criteria.
The Developmental Disability (DD) decision is made by the LGE utilizing the systems entry process. If the individual is determined to meet the DD criteria they are issued a Statement of Approval (SOA), if they do not meet the DD criteria they are issued a Statement of Denial (SOD). Individuals who receive a SOD are informed of their rights to appeal and are provided information regarding the appeals process. Please refer to Fair Hearings/Appeals process as outlined in Appendix F-section F-1 of the waiver document.
The LGE staff conducts a pre-certification home visit to verify accuracy of level of care for all initial evaluations only.

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

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

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

level of care criteria. For Plans of Care approved by the Support Coordination supervisor, the 90-L, Statement of Approval, and Plan of Care are reviewed by the Support Coordination supervisor to assure the participant continues to meet the level of care criteria.
There is no difference in the process for the LOC evaluations and re-evaluations except that LGE staff conduct a pre-certification home visit to verify accuracy of level of care for all initial evaluations. Support Coordination Supervisors approve subsequent annual LOC evaluations as defined by OCDD's policy.
The Developmental Disability decision is made by the LGE staff utilizing the systems entry process. If the individual is determined to meet the DD criteria they are issued a Statement of Approval (SOA), if they do not meet the DD criteria they are issued a Statement of Denial (SOD). Individuals who receive a SOD are informed of their rights to appeal and are provided information regarding the appeals process. Please refer to Fair Hearings/Appeals process as outlined in Appendix F-section F-1 of the waiver document.

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

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

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

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

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

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

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

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
B.a.i.a.1. Number and percentage of initial waiver applicants that have been determined to meet the ICF/DD level of care prior to waiver certification. Percentage = Number of initial applicants who received a level of care determination / Total number of intial applicants reviewed in the sample.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
B.a.i.c.1 Number and percentage of initial applicants who's LOC has been completed following state's procedures. Percentage = Number of initial applicants with a current SOA and current 90-L/Total number of completed initial LOC's reviewed in the sample.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
B.a.i.c.2. Number and percentage of initial waiver applicants level of care evaluations determined to be accurate according to the State's procedures.
Percentage: Number of initial waiver applicants with level of care evaluations determined to be accurate / Total number of initial waiver applications reviewed in the sample.

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Performance Measure B.a.i.a.1, B.a.i.c.1 and B.a.i.c.2: The LGE office reviews all initial applications to ensure that they contain all required information needed to confirm the LOC determination. Any incomplete, untimely, or inaccurate applications are returned by the LGE staff to the support coordinator for correction/clarification. The LGE staff will submit written documentation outlining the reason for the return to the support coordinator. If the system entry eligibility is questioned by the LGE staff as a result of the face to face visit, then the LGE system entry staff will be contacted to ascertain if eligibility re-determination is required.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Performance Measures B.a.i.a.1, B.a.i.c.1, B.a.i.c.2:

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

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

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**

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

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).

• Louisiana Department of Health, Bureau of Health Services Financing, Medicaid Eligibility Determination and the LGE, informs individuals and/or their authorized representatives of the "feasible alternatives" under the waiver and are given the choice of either institutional or home and community-based services at the time a waiver offer is made. LGE currently utilizes the "Case Management Choice and Release of Information Form" to allow the person to state that they understand their choices and the alternatives under the waiver. The information is also reviewed, with the participant and/or authorized representative at a "Pre-certification Home Visit" by LGE staff prior to approval of the initial plan of care and by the Support Coordinator at the annual plan of care meeting.

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 offices of the Support Coordination Agency

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

• The Louisiana Department of Health has a Medicaid Eligibility Supports Section to assist individuals who have language barriers. When the LGE identifies an individual who needs language assistance, the request is submitted to the MPSW Section who reviews and forwards the request to the Eligibility Supports Section to assist the individual. A contracted interpreter is utilized to assist the individual. All forms are published in English, Spanish, and Vietnamese and are available in alternative format upon request.