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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Supports Waiver

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

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
07/01/23
Approved Effective Date of Waiver being Amended: 07/01/19

2. Purpose(s) of Amendment

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

To add the service option of Specialized Medical Equipment and Supplies.
Increase the number of unduplicated beneficiaries for WY4 and WY5

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	

Component of the Approved Waiver	Subsection(s)
☒ Appendix B Participant Access and Eligibility	B.3.a.
☒ Appendix C Participant Services	C-1, C-3
☐ 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	I-2.a.
☒ Appendix J Cost-Neutrality Demonstration	J.2.a, .J-2d.

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:

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.006.03.04

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/19
Approved Effective Date of Waiver being Amended: 07/01/19

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**
If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

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

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

○ **Not applicable**

◉ **Applicable**
Check the applicable authority or authorities:

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

☒ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

LA.0005 Dental Benefit Program (PAHPs)

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

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

☒ **§1915(b)(2) (central broker)**

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

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

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

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

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The 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 1.F and (b) meet the target group criteria specified in **Appendix B**.

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

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

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

- ◉ **No**
- ○ **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

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

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

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

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

In compliance with CMS requirements, OCDD is posting the SW amendment application (LA.006.03.02) for public comment from November 24, 2021 through December 24, 2021. CMS regulations require LDH to actively engage the public and give program participants, advocates, providers and other community stakeholders the chance to provide input regarding changes made to current waiver applications prior to submission of final versions to CMS.

The SW amendment application is posted to the OCDD website and may be accessed at the following address: http://dhh.louisiana.gov/index.cfm/page/2526. A hard copy of the application is available for viewing at the Human Services District/Authority (HSD/HSA) in your region. The HSD/HSA in your region can be found at: http://new.dhh.louisiana.gov/index.cfm/page/134, or by calling 866-783-5553.Implementation of the provisions of this waiver amendment application is contingent upon CMS approval.

Interested persons may submit written comments to the Office for Citizens with Developmental Disabilities, P.O. Box 3117 (Bin #21), Baton Rouge, LA 70821-3117 or by email to ocdd-hcbs@la.gov. The deadline for receipt of all written comments is December 24, 2021, by 4:30 p.m.

There were no public or tribal comments received for this waiver.

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:

Foster-Hagan

First Name:

Julie

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: Julie.Foster@la.gov

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Bennett

First Name: Brian

Title: Section Chief

Agency: Bureau of Health Services Financing

Address: P.O. Box 91030 Bin 24

Address 2:

City: Baton Rouge

State: **Louisiana**

Zip: 70802

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

Fax: (225) 342-9168

E-mail: Brian.Bennett@la.gov

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

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

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

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

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

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The SURGE runs are done monthly. Exceptions identified in the runs are screened and then opened. So the answers are: (1) cases are opened monthly, and (2) the review begins immediately after the case is opened. In addition to the SURGE run, SURS also does an annual HCPCS Outlier run that identifies provider billing patterns of any HCPCs code that are considered outliers and deviate from the norm. The basic concept of the HCPCs Outlier run is to compare a servicing provider's activity for a statistical measurement against a norm for that statistic. In this run, the statistical measurement used is the number of claims paid for every HCPCs code. The run performs exception testing to identify outliers from norms. The Outlier run is done in January of each year and the cases are screened and opened throughout the year.

Each run is coded and submitted against the most recent claim data load. The results vary depending on the number of outliers identified and the results of the screenings. Outliers are screened before a case is opened. Here are some the questions addressed during the screening process: (1) Does SURS currently have a case opened on this provider? If the provider has an open case, we identify what the current status is of the investigation/review; SURS will determine if the SURGE or Outlier data should be added to the existing case or if a new case should be opened. (2) Is the provider actively billing? If the provider's billing has decreased significantly and is no longer a high financial risk impact factor a decision to look at other providers may result. (3) Did SURS recently close a case on this provider? Depending on the data anomalies identified in the runs, a case may not be opened immediately in order to prevent provider abrasion, (4) Is the provider number opened. If the provider file/number has been closed, case review efforts may be diverted to other cases depending on priorities and resources available, etc.

When an overpayment is identified, SURS sends a memo to LDH Fiscal to setup a negative balance on the provider's online file to capture payments thru remittance advices or on offline where the provider would mail in checks via the postal service. We provide Fiscal the recoupment amount, provider name & number and the dates of review. We also send a copy of the provider recoupment letter for backup documentation. Fiscal completes the necessary paperwork (CMS-64) to return the federal share within the required timeframes per CMS.

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 I QIS.

9. Rules, policies, procedures, and information development governing the waiver program – OCDD develops and implements written policies and procedures to operate the waiver and must obtain BHSF approval prior to release of any rulemaking, provider notices, waiver amendments/requests or policy changes. BHSF develops and distributes brochures, flyers, and other informational material regarding available programs to Louisiana citizens. BHSF oversees the website information, as well as communication distribution via Help Lines regarding waiver

eligibility and policy administration.
10. Quality assurance and quality improvement activities - To ensure compliance with federal regulations governing waivers, BHSF created the Medicaid Program Support and Waivers (MPSW) Section to oversee the administration of all Louisiana Medicaid waiver programs. Monitoring is completed under the direction of the MPSW Section Chief. The MPSW Section, through performance measures listed in the Quality Improvement Strategy (QIS) and systems described in Appendix H, ensures that OCDD performs its assigned waiver operational functions including participant health and welfare assurances in accordance with this document. OCDD formally presents performance measures findings/remediation actions to MPSW quarterly via the Medicaid HCBS Oversight Committee.

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

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

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

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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.

The State Medicaid Agency is responsible for the assessment of performance of contracted Dental Benefit Program(PAHPs).

Appendix A: Waiver Administration and Operation

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

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.

Dental Benefit Manager-Please reference LA.005 section b: monitoring plan.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
A.a.i.3 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**

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
A.a.i.7. Number and percentage of waiver offers that were appropriately made across all geographical areas to applicants on the Request for Services Registry (RFSR), according to policy and criteria set forth by the State. Percentage = Number of appropriately made offers to applicants on the RFSR / Total number of waiver offers made

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
A.a.i.6. Number and percent of waiver slots certified annually that are less than or equal to the unduplicated number of participants listed in Appendix B-3-a. Numerator = Number and percent of waiver slots certified annually that are less than or equal to the unduplicated number of participants listed in Appendix B-3-a; Denominator = Total number of slots certified.

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.2 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**
	☐ **Other** Specify:

Performance Measure:
A.a.i.5. 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**

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.4 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:

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

b. Methods for Remediation/Fixing Individual Problems

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

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		☒

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☒	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	2100
Year 2	2300
Year 3	2400
Year 4	2900
Year 5	3000

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

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

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 spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Medically needy with spend down to or below the medically needy income standard using the state average monthly Medicaid rate for residents of Intermediate Care Facilities/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 period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The state uses the post-eligibility rules at 42 CFR 435.726. 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 a government agency under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

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

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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

Performance Measure:
B.a.i.a.1. Number and percentage of initial waiver applicants 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 Level of Care (LOC)

determination has been completed following state's procedures. Percentage = Number of initial applicants who's LOC determination has been completed following state's procedures/Total number of completed initial LOC determinations reviewed in the sample.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
B.a.i.c.2. Number and percentage of initial waiver 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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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

During the Level of Care/Plan of Care (LOC/POC) Quality Review:
• 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**
☒ **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.

Appendix C: Participant Services

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

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Day Habilitation**		
Statutory Service	**Habilitation**		
Statutory Service	**Prevocational Services**		
Statutory Service	**Respite**		
Statutory Service	**Support Coordination**		
Statutory Service	**Supported Employment**		
Extended State Plan Service	**Specialized Medical Equipment and Supplies**		

Service Type	Service		
Other Service	Dental Services		
Other Service	Housing Stabilization Service		
Other Service	Housing Stabilization Transition Service		
Other Service	Personal Emergency Response System		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Day habilitation should focus on the person centered planning process, which would allow the participant a choice in how they spend their day. Day Habilitation is furnished in a variety of community settings, (i.e. local recreation department, garden clubs, libraries) other than the person's residence and is not to be limited to a fixed- site.
Day habilitation activities should assist the participant to gain their desired community living experience, including the acquisition, retention or improvement in self-help, socialization and adaptive skills, and/or to provide the individual an opportunity to contribute to his or her community. Day Habilitation activities should be educational or recreational in nature, which would include activities that are related to the individual's interests, hobbies, clubs, or sports.
For individuals with degenerative conditions, day habilitation may include training and supports designed to maintain skills and functioning and to slow or prevent regression rather than acquiring new skills or improving existing skills. Day Habilitation Services may be coordinated with needed therapies in the individual's person-centered Plan of Care.
The individual of retirement age may also be supported in senior community activities or other meaningful retirement activities in the community, such as the local council on aging or senior centers.
Career planning activities may be a component of the participant's plan and may be used to develop learning opportunities and career options consistent with the person's skills and interests.
Day habilitation may not provide for the payment of services that are vocational in nature – for example, the primary purpose of producing goods or performing services.
Assistance with personal care may be a component part of day habilitation services as necessary to meet the needs of a participant, but may not comprise the entirety of the service. Payment for any meals provided does not include a full nutritional regimen of 3 meals per day
Volunteer activities should be provided under the guidelines of the United States Fair Labor Standards Act of 1985 as amended.
Participants receiving Day Habilitation Services may also receive Prevocational or individual Supported Employment services, but these services cannot be provided during the same time period and cannot equal more than 5 hours per day.
Day Habilitation services are broken into 2 services:
1. Onsite Day Habilitation is typically delivered in a ratio of 1:8. Services can be delivered onsite inside of a day program building. This service should focus on the person centered planning process, which allows the participant a choice in how they spend their day and should take into account how their time is spent when using Community Life Engagement services. Onsite Day Habilitation activities should be consistent with the individual's interests, skills and desires and should assist the participant to gain their desired meaningful day. Onsite Day Habilitation can also be offered in a variety of community settings, (i.e. local recreation department, garden clubs, libraries). The community should be a regular part of onsite day habilitation activities including volunteers and community partnerships and engagement. However, the use of 'reverse integration' does not supplant the inclusion of community life engagement. Virtual delivery of Day Habilitation is allowed for this service.
2. Community Life Engagement is typically delivered in a small group of 1-2/4 or 1:1 as needed and is delivered in the community only. When planning for this service, the Person Centered Planning Process should be used for each person to develop a plan for how the individual wants to engage in their community including the frequency and activities.
Community Life Engagement refers to services that help support individuals with disabilities to access and participate in purposeful and meaningful activities in their community. The role of CLE varies depending on the particular needs of the individual. This service promotes opportunities and support for community inclusion; building interests and developing skills and potential for not only meaningful community engagement but also it can help the individual in figuring out areas of interests that could lead to possible competitive integrated employment in the community. Services should be completed in the community in small groups of at least 2 to 4 individuals, which allows for a more person centered planning of activities. Services should result in active, valued participation and engagement in a broad range of integrated activities that build on the participant's interests, preferences, gifts, and strengths while reflecting his or her desired outcomes related to community involvement and membership. This service involves participation in integrated community settings, in activities that include persons without disabilities and with people who are not paid or unpaid caregivers. This service is expected to result in the individual developing and maintaining of social roles and relationships; building natural supports; increasing independence; increasing potential for employment and/or experiencing meaningful community participation and inclusion. Volunteering is expected to be a part of this service as well.
Requirements:

- Use an approved activity log to document activities done in the community and frequency
- Electronic Visit Verification must be utilized
- Services may be delivered during the days and times that activities are available. There are no limits to the days

or times. Services can be delivered during the day, evenings and/or weekends.

- Community Life Engagement cannot be delivered at the same time as any other service.

Virtual delivery of Day Habilitation should be utilized during times that does not allow the beneficiary to attend in person (i.e. medical issues/surgery, an emergency where a provider agency may be closed or when the beneficiary chooses to not attend in person. Virtual delivery is not the typical delivery method. In order to participate in virtual delivery of the service, the beneficiary should be independent or have natural supports, as this service cannot be billed at the same time as another service. The beneficiary should also have the technology necessary to participate in the virtual service.(i.e. internet connection, laptop, smartphone, tablet). Prior to the beginning of virtual delivery the following In-person visits are required:

- An initial assessment of beneficiary and home to determine if it's feasible
- HIPPA compliance training prior to beginning virtual delivery

Beneficiaries are encouraged to participate in the community through Community Life Engagement services or onsite day habilitation services in person.

Virtual delivery of day habilitation will be discussed with each beneficiary by the support coordinator as well as with the service provider and will be included in the plan of care if chosen by the beneficiary.

To assure that virtual delivery of day habilitation meets HIPAA requirements, the following will occur:

Providers will receive written instructions on the delivery of virtual services based on the HIPAA compliance officer's instructions.

When using virtual delivery, providers will follow these guidelines:

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

Providers will ensure that beneficiaries understand the guidelines for participation in a virtual service delivery and HIPAA. Written instructions and guidelines will be provided to each beneficiary.

Beneficiaries and natural supports will be instructed on the following:

- finding a space that allows for privacy while participating in the service
- turn the camera off and mute the session if they leave to go to the bathroom or leave the room while participating in the session, or if someone who is not part of the group comes into the room.
- how to utilize the technology required to participate in the virtual delivery of day habilitation, including how to utilize the specific format, signing in and out etc. The provider will also provide written instructions

To ensure that virtual delivery of day habilitation facilitates community integration, the provider agency will continue to incorporate already established community partners into the virtual delivery of day habilitation. For instance, if a meeting that is typically attended in the community with community participation occuring, the beneficiary will join via a face-to-face format virtually and therefore still be included in the meeting. Providers will also seek opportunities for beneficiaries to join community online groups in a face-to-face format and seek out such activities as online church services and groups, exercise classes, cooking and drawing classes. Through virtual delivery of this service, beneficiaries can continue to interact with their friends and community connections during the times when the beneficiary is not participating in person. If the beneficiary is able to be unsupported during this service, an existing protocol is in place for the person if a health and safety issue arises during this virtual service. The provider agency staff, who is conducting the virtual delivery of this service, will be able to support the beneficiary through any health and safety situation that might arise during the virtual delivery of day hab. If the beneficiary is participating in virtual services with the assistance of natural supports, the natural supports will ensure the health and safety of the beneficiary.

All virtual day habilitation services must be on the approved Plan of Care and should be delivered as outlined in the OCDD Policy and Procedures manual.

Minimum Requirements for VDH:

- Must utilize a virtual format that allows for face-to-face interaction

- Must utilize EVV to check in and out of VDH
- Must utilize an approved Activity Log to track the days, times and activities that the participant is utilizing VDH

All transportation costs are included in the reimbursement for onsite Day Habilitation services. Transportation needed by the participant must be documented on service plan. Participant must be present to receive this service. If participant needs transportation, Provider must physically provide, arrange for, or pay for appropriate transport to and from a central location convenient for the participant agreed upon by the Team; this location shall be documented in the service plan.

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

Day Habilitation services are to be provided on a regularly scheduled basis and may be scheduled on a Plan of Care for 1 or more days per week and may be prior authorized for up to 4800 units of service in a plan of care year with appropriate documentation.
A standard unit is 15 minute increment.
Post authorization may be approved upon verification of services rendered.

Participants receiving Day Habilitation Services may also receive Prevocational and/or Individual Supported Employment services, but these services cannot be provided during the same time period and cannot total more than 5 hours combined.
Participants receiving any method of delivery for day habilitation services can receive other services on the same day but cannot be delivered during the same time period as other services. This service cannot be delivered on the same day as group employment as group employment is a daily rate.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Adult Day Care

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Initially and Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Habilitation

HCBS Taxonomy:

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

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Habilitation is provided in the home or community, with the participants place of residence as the primary setting. Habilitation offers services designed to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community settings in the State of Louisiana. Habilitation services may be provided at any time of day or night on any day of the week as needed by the participant to achieve a specified goal, and may only be provided on a one staff to one participant ratio. Habilitation services are educational in nature, and focus on achieving a goal utilizing specific teaching strategies. Goals may cover a wide range of opportunities including but not limited to learning how to clean house; do laundry; wash dishes; grocery shop; bank; cook meals; shop for clothing and personal items; become involved in community recreational and leisure activities; do personal yard work; and utilize transportation to access community resources.

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

Habilitation shall not exceed 285 standard units of service in a plan year.
Participants receiving Habilitation may use this service in conjunction with other Supports Waiver services as long as services are not provided during the same period in a day. To ensure that there is no duplication of service when a participant chooses both Habilitation and Day Habilitation services the Support Coordinator will facilitate development of a service plan that clearly specifies the training supports, staff ratio and time lines that will be provided for each service. In addition, the Provider(s) of each service must submit a detailed plan to the Support Coordinator that provides information on the specific educational strategies and time lines for those strategies that will be used to achieve the goals and time lines on the service plan.
Habilitation services may be provided at any time of day or night on any day of the week as needed by the participant to achieve a specified goal, and may only be provided on a one staff to one participant ratio.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Care Attendant
Individual	Therapeutic Recreational Specialist
Individual	Physical Therapist
Agency	Adult Day Care
Individual	Occupational Therapist

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Habilitation

Provider Category:

Agency

Provider Type:

Personal Care Attendant

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Initially, annually and as needed

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Habilitation

Provider Category:

Individual

Provider Type:

Therapeutic Recreational Specialist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

National Council for Therapeutic Recreation Certification (NCTRC)

Other Standard *(specify):*

NCTRC Standards, Policies and Procedures, December 2005 and as amended

Verification of Provider Qualifications

Entity Responsible for Verification:

National Council for Therapeutic Recreation Certification
Department of Health and Hospitals (Health Standards Section)

Frequency of Verification:

Initially and Every 5th year thereafter

Initally and annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Habilitation

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

Physical Therapy Practice Act:
Louisiana Revised Statutes
37.2401-2421 as amended through 2004

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana State Board of Medical Examiners
Louisiana Department of Health (Health Standards Section)

Frequency of Verification:

Initally, annually and as needed

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Habilitation

Provider Category:

Agency

Provider Type:

Adult Day Care

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Initially, annually and as needed

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Habilitation

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

Occupational Therapy
Louisiana Revised Statute: RS 37:3001-3014

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana State Board of Medical Examiners
Louisiana Department of Health (Health Standards Section)

Frequency of Verification:

Initially, annually and as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

Prevocational Services also referred to as Career Planning services, are designed to create a path to integrated, individual, community-based employment for which an individual is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.
Good candidates for prevocational services may include individuals who want to work but may not be sure where their interests lie and need to explore further options.
Career Planning is not a required pre-requisite for individual supported employment services and at any time during this service, one may choose to leave it either because they want to go to work immediately or because they are no longer interested in working.
This service is best completed in the community and in practical situations, but there are some options for activities that can be completed onsite. This service should be delivered in the community utilizing locations such as businesses, Workforce Job Centers and other places that can assist the individual in developing skills and competencies necessary for an individual to be employed in a competitive job. A variety of career exploration activities such as individual discovery activities, career education, career assessments and financial education should occur during this service. Activities that could occur include volunteering, internships and mentoring. The outcome of this service should be a personal career profile and will provide valuable information for the next phase of the career path.
Career Planning services may be provided in a variety of settings including home visits conducted as part of individual discovery and getting to know the individual in their day to day life.
This service is a time limited service as defined in the OCDD policy and procedures manual and a targeted service for people wanting to become employed but may need additional information and experiences in order to determine such things as their areas of interests for work, skills and strengths and conditions needed for successful employment.
Assistance with personal care may be a component of prevocational services, but may not comprise the entirety of the service.
PREVOCATIONAL SERVICES has two distinct services.
1. Onsite Prevocational Services also referred to as onsite career planning services can be delivered in a 1:8 ratio ratio depending upon the individual's needs. These services are intended to support the individual in developing general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Examples of general skill development include: how to communicate effectively with supervisors, co-workers, and customers; accepted community workplace conduct and dress; attention to tasks and directions; workplace problem solving skills and general workplace safety and mobility training. Onsite Services could consist of activities such as: making contact with businesses and research via the internet opportunities for career options through internships, mentoring opportunities, volunteer positions and community exploration. As part of this service business tours can be completed to assist in determining a direction for employment. Career exploration and discovery activities should be part of this service. This service should be individualized and should be used in the development of a career plan 'profile' for each person.
Onsite Career Planning services should consider the community career planning services and should work together to accomplish the goals set forth.
2. Community Career Planning is delivered in a small group with a ratio of 1:2/4 but can also be delivered in a 1:1 ratio. This service is an individualized, person-centered, comprehensive service that assists the individual in establishing their path to obtain individual, competitive integrated employment in the community. The outcome of this service is to create a 'Profile' for each person that can be utilized to create their employment plan.
Career Planning Services are designed to create a path to individual, integrated community based employment for which an individual is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.
Career Planning services are intended to use the person centered planning process to discover the various interest, skills and general information about each person that will assist in developing a path to employment in the community. Based off the person centered planning, activities should be tailored for each person in preparing them for paid employment in the community.
Virtual delivery of Prevocational services may occur.
There is not a predetermined percentage of time that virtual delivery of services will occur as this is an individual choice to participate in this delivery method or not. Virtual service delivery is an option during times that does not allow the beneficiary to attend in person (i.e. medical issues/surgery), an emergency or when the beneficiary chooses to not attend in-person for personal reasons. The beneficiary should be independent or have natural supports, as this service cannot be billed at the same time as another service. The beneficiary must have the means necessary to participate in the virtual service, (i.e. laptop, tablet, etc.).
Virtual delivery is not the preferred method as beneficiaries are encouraged to participate in the community through

either onsite prevocational or community career planning services and are offered these options as well. Virtual delivery will be included in the discussion with each beneficiary by the support coordinator and the service provider and will only be included in the plan of care if chosen by the individual. Prior to the beginning of virtual delivery the following In-person visits are required:

- An initial assessment of beneficiary and home to determine if it's feasible
- HIPPA compliance training prior to beginning virtual delivery

To assure that virtual delivery of this service meets HIPAA requirements, the following will occur:
Providers will receive written instructions on the delivery of virtual services based on the HIPAA compliance officer's instructions.
When using virtual delivery, providers will follow these guidelines:

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

Providers will ensure that beneficiaries understand the guidelines for participation in a virtual service delivery and HIPAA. Written instructions and guidelines will be provided to each beneficiary.
Beneficiaries and natural supports will be instructed on the following:

- finding a space that allows for privacy while participating in the service
- turn the camera off and mute the session if they leave to go to the bathroom or leave the room while participating in the session, or if someone who is not part of the group comes into the room.
- how to utilize the technology required to participate in the virtual delivery of this service, including how to utilize the specific format, signing in and out etc. The provider will also provide written instructions

To ensure that virtual delivery of this service facilitates community integration, the provider agency will continue to incorporate already established community partners into the virtual delivery of the service. For instance, if the beneficiary typically attends a career exploration class in the community with community participation occurring, the beneficiary will join via a face-to-face format virtually and therefore still be included in the meeting. Providers will also seek opportunities for beneficiaries to join community online groups in a face-to-face format and seek out such activities as career preparation, mock interview sessions etc. Through virtual delivery of this service, beneficiaries can continue to interact with their friends and community connections during the times when the beneficiary is not participating in person but will allow for the beneficiary to not miss out on opportunities for inclusion.
If the beneficiary is able to be unsupported during this service, an existing protocol is in place for the person if a health and safety issue arises during this virtual service. The provider agency staff, who is conducting the virtual delivery of this service, will be able to support the beneficiary through any health and safety situation that might arise during the virtual delivery of prevoc. If the beneficiary is participating in virtual services with the assistance of natural supports, the natural supports will ensure the health and safety of the beneficiary.

All virtual delivery of prevocational services must be on the approved Plan of Care and must be delivered as outlined in the OCDD Policy and Procedures manual.
Minimum Requirements for virtual delivery:

- Must utilize a virtual format that allows for face-to-face interaction
- Must utilize EVV to check in and out of the service
- Must utilize an approved Activity Log to track the days, times and activities that the participant is utilizing virtual delivery

All transportation costs are included in the reimbursement for onsite Prevocational services. Transportation needed

by the participant must be documented on the service plan. Participant must be present to receive this service. If participant needs transportation, Provider must physically provide, arrange, or pay for appropriate transport to and from a central location convenient for the participant agreed upon by the Team; this location shall be documented in the service plan.
Through special permission from the Local Governing Entity and under special circumstances as outlined in the OCDD Policy and Procedures manual, a person can complete this service more than once. An individual can leave CP at any time to pursue employment or if they decide they do not want to pursue employment at this time. Participation in CP is not a requirement in order for the individual to go to work
Volunteer activities should be provided under the guidelines of the United States Fair Labor Standards Act of 1985 as amended

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

Prevocational services are provided on a regularly scheduled basis and may be scheduled on a Plan of Care for 1 or more days per week and may be prior authorized for up to 4800 units of service in a plan of care year with appropriate documentation.
A standard unit is 15 minute increment.
Prevocational services are time limited as outlined in the OCDD policy and procedures manual.
Post authorization may be approved upon verification of services rendered.
Participants receiving Prevocational Services may also receive a Day Habilitation or Individual Supported Employment service, but these services cannot be provided during the same time period and the total of the services cannot equal more than 5 hours per day.
Prevocational services should not be delivered on the same day as Group Employment as it is paid at a daily rate.
Prevocational Services are not available to individuals who are eligible to participate in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Individuals with Disabilities Education Act, 20 U.S.C. 1401 (16) and (71).

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Adult Day Care

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Site supervisor must have 15 hours of employment based training annually

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Initially and Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite

HCBS Taxonomy:

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

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Respite can be provided in the participants home or private residence, or in a licensed respite care facility determined appropriate by the participant or responsible party. Respite in the participant's home or private residence can be utilized to assist the participant in their home or in the community and to provide direct care as needed to complete everyday personal tasks. Center-based respite care is a service provided to participants who are unable to care for themselves; furnished on a short-term basis due to the absence or need for relief of those persons normally providing the care. Respite care will only be provided in a licensed center-based respite care facility. It is most commonly used when families take vacations, go away for the weekend, or have a sudden emergency such as a death in the family. It is not substitute family care.

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

Respite shall not exceed 428 standard units of service in a plan year.
Participants receiving Respite may use this service in conjunction with other Supports Waiver services as long as services are not provided during the same period in a day.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Care Attendant
Agency	HCBS- Center Based Respite Module

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Personal Care Attendant

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Initially, annually and as needed

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

HCBS- Center Based Respite Module

Provider Qualifications

License *(specify):*

Home and Community Based Services Provider Licensing Standards-
LAC 48:1.Chapter 50

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Department of Health (Health Standards Section)

Frequency of Verification:

Initially, annually and as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Support Coordination

HCBS Taxonomy:

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

Service Definition *(Scope):*

Support Coordination consists of the coordination of supports and services that will assist participants who receive Supports Waiver services in gaining access to needed waiver and other Medicaid services, as well as needed medical, social, educational and other services, regardless of the funding source. The support coordinator is responsible for convening the person-centered planning team comprised of the participant, participant's family, direct service providers, medical and social work professionals, as necessary, and advocates, who assist in determining the appropriate supports and strategies to meet the participant's needs and preferences. The support coordinator shall be responsible for the ongoing coordination of supports and services included in the participant's plan of care.

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

at least monthly contact and quarterly face to face visits. Virtual meeting may be allowed if criteria is met as defined in the OCDD Policy and Procedures manual. If a virtual meeting is held, electronic verification is acceptable.

Billed in a monthly unit for 12 months.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Support Coordination

Provider Category:

Agency

Provider Type:

Case Management

Provider Qualifications

License *(specify):*

Case Management Licensing Standards:
LAC 48:I. Chapter 49 4901-4981 LR Vol. 20 No. 8 August 20, 1994.

Certificate *(specify):*

Other Standard *(specify):*

Providers must enroll as a Medicaid Case Management provider.

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

Support coordination agencies are required to perform the activities
• Intake,
• Assessment,
•Plan of Care Development and Implementation,
•Follow-Up/Monitoring,
•Reassessment, and
•Transition/Closure

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Department of Health (Health Standards Section)

Frequency of Verification:

Initially, annually, and as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
03 Supported Employment	03022 ongoing supported employment, group
Category 3:	**Sub-Category 3:**
03 Supported Employment	03010 job development
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Supported Employment - Individual
Individual Employment support services are the ongoing supports provided to participants who, because of their disabilities, need intensive on- going support to obtain and maintain an individual job in competitive or customized employment or self- employment in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.
The outcome of this service is sustained paid employment in an integrated setting in the general workforce in the community in a job that meets personal and career goals. May also include support to establish or maintain self-employment, including home based self-employment.
Supported employment services may include any combination of the following services: vocational/job related discovery or assessment, person centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instructions, job coaching, benefits support, training and planning, transportation, asset development, and career advancement services, and other workplace support services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.
Participants who have the most significant disabilities may also need long-term employment supports to successfully maintain a job due to the ongoing nature of the waiver participant's support needs, changes in life situations or evolving and changing job responsibilities and where natural supports would not meet this need.
SE individual employment supports does not include volunteer work.
SE individual employment supports does not include facility based or other types of vocational services furnished in specialized facilities that are not a part of the general work place.
Virtual Individual SE Follow-along Services are delivered in a 1:1 ratio. These services are delivered based on the already determined amount of follow along services necessary for the individual to maintain their employment. There is not a predetermined percentage of time that virtual services will occur as this is an individual choice.
Virtual delivery of one to one Ongoing Supported Employment Follow Along is based on the beneficiary's needs for what is required to support the beneficiary on the job.
In-person visits are required in the following circumstances as outlined:
- An initial assessment of beneficiary, job site,
- Discussion of HIPAA compliance prior to beginning virtual services

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

Providers will ensure that beneficiaries understand the guidelines for participation in a virtual service delivery, HIPAA and the use of the technology. Written instructions and guidelines will be provided to each beneficiary.
Beneficiaries and employer will be instructed on the following:
- finding a space that allows for privacy while participating in the virtual delivery of the service

- to turn the camera off and mute the session if the beneficiary leaves the room while participating in the session, or if someone who is not part of the session enters the room
- how to utilize the technology required to participate in the virtual delivery of this service, including how to utilize the specific format, signing in and out etc. The provider will also provide written instructions to the beneficiary.
- Schedule the delivery of services
- Directions if job coach is needed unexpectantly

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

Requirements for virtual visits include:
- Must utilize some type of format that allows for face to face interaction
- Must be approved by LGE or OCDD State Office
- Utilize the Virtual Supported Employment Follow-along Services Report
- This service cannot be utilized at the same time another service

Individual Supported Employment is broken down into the following categories:
1) Job Assessment, Discovery and Development for Individual Jobs or Self Employment
2) Initial Job Support, Job Retention and Follow along for Individual Jobs or Self Employment
3) Virtual Delivery of Individual Supported Employment Follow Along

Transportation is an allowable activity within Individual Supported Employment, but whenever possible, family, neighbors, friends, co-workers or community resources that can provide needed transportation without charge should be utilized.
Participants receiving Supported Employment Services may also receive other services including Prevocational or Day Habilitation services, but these services cannot be provided in the same service day. Group Employment cannot be delivered on the same day as individual SE services as group employment is a daily rate.
There must be documentation in the participant's file that these services are not available from programs funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Supported Employment-Group:

Services and training activities provided in regular business, industry, and community settings for groups of ratios of 1:1-2, 1:3-4 or 1:5-8. SE group must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces.
The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community–based employment.
At anytime an individual can decide to pursue individual employment and leave group employment.
An individual can participate in the Community Career Planning service to further explore interest to pursue individual community employment.
Personal care/assistance may be a component part of supported employment small group employment support services, but may not comprise the entirety of the service.
Group employment does not include vocational services provided in facility based work settings.
Group employment does not include volunteer work.
Services are broken down as follows:
1) Job Assessment, Discovery, and development for group:
2) Initial job support, Job Retention, and follow along for group:

All transportation costs are included in the reimbursement for group employment support.
Participants receiving Supported Employment, Group Services may also receive other services including Prevocational or Day Habilitation services, but these services cannot be provided in the same day.
There must be documentation in the participant's file that these services are not available from programs funded

under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

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

1) For Job Assessment, Discovery and Development for Individual Jobs or Self Employment, A standard unit is defined as 15 minute increments. 2880 standard units of service are allowed in a plan year.

2) For Initial Job Support, Job Retention and Follow along for Individual Jobs, including virtual delivery of Individual Follow Along or Self Employment, a standard unit is defined as 15 minute increment. 960 standard units of service are allowed in a plan year.

3) For Job Assessment, Discovery and Development for Group Employment, a standard unit is defined as 15 minute increment. 480 standard units of service are allowed in a plan year.

4) For Initial Job Support, Job Retention and Follow along for Group Employment, a standard unit is defined as 1 or more hours a day. Providers must provide at least 1 hour of service in order to receive reimbursement. 240 standard units of service are allowed in a plan year.

Participants receiving Individual Supported Employment Services may also receive other services including Prevocational or Day Habilitation services, but these services cannot be provided during the same time period of the day and the total number of hours can not exceed 5 hours of service in a day.
Participants receiving Group Employment Supported Services may also receive prevocational services and day habilitation services, however they can not be provided in the same service day.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care
Agency	Community Rehabilitation Programs (CRP) who are enrolled Medicaid providers of Supported Employment Services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Adult Day Care

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Completion Certificate of the approved Supported Employment initial 40 hour training program by an approved vendor and the annual training - (same training that is completed by the CRP)

Other Standard *(specify):*

Adult Day Care Site Supervisor must have 15 hours of employment based training annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

OCDD Provider Relations

Frequency of Verification:

Initially and annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Louisiana Rehabilitation Services (LRS) Community Rehabilitation Program Vendor Compliance Certification

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Louisiana Workforce Commission,
Louisiana Rehabilitation Services

Frequency of Verification:

Initally and Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Beneficiaries, ages 21 years and older, can receive incontinence supplies, such as incontinence briefs and other incontinence related items as defined in state policy. Supports provided by this service will allow the beneficiary the ability to improve and maintain their ability to remain engaged in community related activities.

Beneficiaries, ages 21 years and younger, will receive their incontinence supplies through Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

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

The beneficiary must be at least 21.
The beneficiary must have a physician's order and updated annually.
This service is capped at $2500.00 per Plan of Care (POC) year per beneficiary.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assistive Devices

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Assistive Devices

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must meet all applicable vendor standards and/or requirements to be a Medicaid enrolled provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Fiscal Intermediary

Frequency of Verification:

Initially and annually and as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Dental Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11070 dental services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

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

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

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

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Dentist-Individual and Group

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dental Services

Provider Category:

Individual

Provider Type:

Dentist-Individual and Group

Provider Qualifications

License *(specify):*

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

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

PAHP

Frequency of Verification:

Initially and every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Housing Stabilization Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

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

1. Conduct a housing assessment identifying the participant's preferences related to housing (type, location, living alone or with someone else, accommodations needed, other important preferences) and needs for support to maintain housing (including access to, meeting terms of lease, and eviction prevention), budgeting for housing/living expenses, obtaining/accessing sources of income necessary for rent, home management, establishing credit and understanding and meeting obligations of tenancy as defined in lease terms.
2. Assist participant to view and secure housing as needed. This may include arranging or providing transportation. Assist participant to secure supporting documents/records, completing/submitting applications, securing deposits, locate furnishings.
3. Develop an individualized housing stabilization service provider plan based upon the housing assessment that includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies where other provider(s) or services may be required to meet the goal.
4. Participate in the development of the plan of care, incorporating elements of the housing stabilization service provider plan. Participate in plan of care renewal and updates as needed.
5. Provide supports and interventions per the individualized housing stabilization service provider plan. If additional supports or services are identified as needed outside the scope of Housing Stabilization Services, communicate the needs to the Support Coordinator.
6. Communicate with the landlord or property manager regarding the participant's disability, accommodations needed, and components of emergency procedures involving the landlord or property manager.
7. If at any time the participant's housing is placed at risk (eg.,eviction, loss of roommate or income), Housing Stabilization Services will provide supports to retain housing or locate and secure housing to continue community based supports including locating new housing, sources of income, etc.

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

Available only to participants who:
- Are residing in a State of Louisiana Permanent Supportive Housing unit or
- Are linked for the State of Louisiana Permanent Supportive Housing selection process

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Permanent Supportive Housing Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Housing Stabilization Service

Provider Category:

Agency

Provider Type:

Permanent Supportive Housing Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Community Psychiatric and Support Team

Other Standard *(specify):*

Permanent Supportive Housing (PSH) Agency under contract and enrolled with the Louisiana Department of Health Statewide Management Organization for Behavioral Health Services plus either:

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Adult and Aging Services, (OAAS), the program office housing the PSH director

Frequency of Verification:

Initially and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Housing Stabilization Transition Service

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

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

Available only to participants who:

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

Limited to:

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Permanent Supportive Housing Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Permanent Supportive Housing Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Community Psychiatric and Support Team

Other Standard *(specify):*

Permanent Supportive Housing (PSH) Agency under contract and enrolled with the Louisiana Department of Health Statewide Management Organization for Behavioral Health Services plus either:
1. meeting requirements for completion of training program as verified by the PSH director; or
2. have at least one year of completion of housing support team experience in the PSH program as verified by the PSH director.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Adult and Aging Services (OAAS), the program office housing the PSH director

Frequency of Verification:

Initially and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

A Personal Emergency Response System (PERS) is an electronic device connected to the participant's phone, which enables a participant to secure help when needed. The system is programmed to send a signal to the response center once a "help" button is activated. Trained professionals staff the response center.

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

Coverage of the PERS is limited to the rental of the electronic device. The fee includes a one-time instalation charge, training to the participant in usage of the equipment and a monthly maintenance fee.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Emergency Response System supplier

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Personal Emergency Response System supplier

Provider Qualifications

License *(specify):*

Applicable city or parish business license

Certificate *(specify):*

Other Standard *(specify):*

Provider must install and support PERS equipment in compliance with all applicable federal, state, county (parish) and local laws and regulations and meet manufacturer's specifications, response requirements, maintenance records, and enrollee education
Enrolled Medicaid provider

Verification of Provider Qualifications

Entity Responsible for Verification:

(Medicaid Fiscal Intermediary): For Medicaid enrollment
City or Parish issuing business license

Frequency of Verification:

Medicaid Fiscal Intermediary: Initially and Annually
City/Parish issuing business license:
As required by individual city or parish

Appendix C: Participant Services

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

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

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

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

Appendix C: Participant Services

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

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

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

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

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

• The Louisiana State Police (LSP), or the LSP designee companies they recognize as competent, perform the actual criminal history/background checks and security check on the individual.

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

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

• LA R.S. 14:403.2 XI-B; abuse and neglect of adults (includes disabled adults); and

• LA R.S. 40:1300.53, “Criminal History Checks on Non-licensed Persons and Licensed Ambulance Personnel” and LA R.S. 40:1300.52 statutes were redesignated by HCR 84 of the 2015 Regular Legislative Session as LA R.S. 40-1203.3 and LA R.S. 40-1203.2 respectively. These statutes require the criminal background check to include a security check. The security check will search the national sex offender public registry. All direct support provider agencies are encouraged to become familiar with, and have on hand, the above mentioned statutes as a reference when hiring.

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

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

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

Appendix C: Participant Services

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

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

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

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

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

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

- [ ] **Self-directed**
- [ ] **Agency-operated**

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

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

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

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

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

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

During periods of emergency, participants may live with their direct support staff on a temporary basis as allowed, in writing, by the OCDD Assistant Secretary/designee.

○ **Other policy.**

Specify:

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

• Willing and qualified Licensed HCBS providers can access information on becoming an enrolled waiver service provider several ways:
o. Via the Louisiana Medicaid website;
o. Through state facilitated stakeholder meetings regarding waiver services; and
o. Through state facilitated meetings with provider organizations such as ARC of Louisiana, Community and Residential Services Association, Alliance of Direct Support Professionals, and Alliance of Support Coordinators.
• To date, Louisiana has not had a problem finding enough willing and qualified providers to enroll as waiver service providers.
• As per the Interagency Agreement between the Medicaid Bureau of Health Services Financing (BHSF) and the OCDD:
o. All willing and qualified providers have the opportunity to enroll as waiver service providers by first obtaining a license for the specific service they wish to provide through the Department of Health and Hospitals, Health Standards Section (HSS);
o. BHSF/HSS trains all DD waiver providers in licensing and certification procedures and requirements;
o. After obtaining a license, the provider applicant must complete a Medicaid Enrollment Application and sign a Louisiana Provider Enrollment form (PE-50) to enroll and participate in the Medicaid program;
o. BHSF, or its designee, reviews all information, and makes a determination whether to enroll the provider in the Medicaid program;
o. BHSF, or its designee, assigns each new enrolled provider a unique Medicaid provider number and sends the OCDD/HSS this information;
o. The provider's name is then added to the Freedom of Choice list;
o. BHSF, OCDD, or its agent train DD waiver providers in the proper procedures to follow in submitting claims to the Medicaid program BHSF handles all questions concerning the submission of claims;
o. BHSF/HSS is responsible for insuring that DD waiver providers remain in compliance with all rules and regulations required for participation in the Medicaid program; and
o. HSS, or its designee notifies OCDD State Office in the event any previously enrolled waiver services provider is removed from the active Medicaid provider files. This notification includes the effective date of the closure and the reason.

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

Willing and qualified providers can access information on becoming an enrolled waiver service provider several ways:
Via the Louisiana Medicaid website;
Through state facilitated stakeholder meetings regarding waiver services; and
Through state facilitated meetings with provider organizations such as ARC of Louisiana, Alliance of Direct Support Professionals, and Alliance of Support Coordinators.
To date, Louisiana has not had a problem finding enough willing and qualified providers to enroll as waiver service providers.
As per the Interagency Agreement between the Medicaid Bureau of Health Services Financing (BHSF) and the OCDD:
All willing and qualified providers have the opportunity to enroll as waiver service providers by first submitting a facility needs review packet to LDH, Office of Management and Finance, Health Standards Section. Upon approval of the facility needs review, a license is issued.
After obtaining a license, the provider applicant must complete and sign a Louisiana Provider Enrollment form (PE-50) to participate in the Medicaid program;
BHSF, or its designee, reviews all information, and makes a determination whether to enroll the provider in the Medicaid program;
BHSF, or its designee assigns each new enrolled provider a unique Medicaid number and sends the OCDD this information;
The Provider's name is then added to the Freedom of Choice list;
BHSF trains all waiver providers in licensing and certification procedures and requirements;
BHSF, OCDD, or its agent train waiver providers in the proper procedures to follow in submitting claims to the Medicaid program Fiscal Intermediary Provider relations handles all questions concerning the submission of claims;
BHSF is responsible for insuring that waiver providers remain in compliance with all rules and regulations required

for participation in the Medicaid program; and

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

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

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify: Health Standards Section	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Combination of complaint surveys and licensures
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

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

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

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

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

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

Data Aggregation and Analysis:

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

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

C.a.i.c.1: LDH is required to maintain a registry of individuals to include information concerning any documentation of any investigation for findings of abuse, neglect, extortion, exploitation and misappropriation of property, including a summary of findings after an action is final. Employers must use the registry to determine if there is a finding of abuse, neglect or misappropriation. An individual with a finding of abuse, neglect or misappropriation on the registry may not be hired.

C.a.i.a.2: A provisional license may be issued to a provider that has deficiencies which are not a danger to the health and welfare of clients. They are issued for a period up to six months. Providers who fail to attain substantial compliance following the issuance of a provisional license may be denied license renewal or may have the license revoked.

b. Methods for Remediation/Fixing Individual Problems

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

For services provided in the waiver, the general remediation procedure the State utilizes if for the LGE staff to review data on corrective actions and identify which items are unclear or need revision. Staff work with the provider to ensure that the corrective action plan is clear, reasonable and has been implemented to address the concerns.

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR

441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Please see Attachment #2

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Plan of Care (POC)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other**

direct waiver services to the participant.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Following selection of and linkage to a support coordination agency, the assigned support coordinator explains all available services in the Waiver during the initial contact so that the participant and his/her family/legal representatives can make informed choices. The participant is also informed of any procedural safeguards, their rights and responsibilities, how to request a change of Support Coordination agencies or Direct Service Providers, and the grievance and/or complaint procedures. The Support Coordinator provides assistance in gaining access to the full range of needed services including medical, social, educational, and/or other supports as identified by the participant.

The initial meetings are conducted in face-to-face visits preferably in the participant's place of residence. Virtual meeting may be allowed if criteria is met as defined in the OCDD Policy and Procedures manual.
Virtual visits are allowed if the following conditions are met:

1. The beneficiary/family is in agreement that a virtual visit is in the best interest of the beneficiary, and
2. The SC is in agreement, and
3. The provider agencies are in agreement, and
4. The legally responsible beneficiaries or family members living in the home are not paid caregivers, and
5. There are no instances in the past two years, and
   - Discovery by SC or reported by provider of an accident, incident, injury that meets Critical Incident Review Criteria
   - Lack of desired personal outcomes: such as education, employment, and community engagement
   - Unsafe living conditions, lack of sanitation, lack of food and supplies
   - Change in involvement of natural supports
   - Medication issues
   - Changes in behavior, medical status or appearance (weight gain/loss)
6. Technology is available to complete the visit with direct observation of the beneficiary and the home, and there is evidence that the requirements for the quarterly visit can be completed virtually

If a virtual meeting is held, electronic verification is acceptable. The State will follow the HIPAA requirements and will obtain electronic signatures via secure mail. During this visit, the participant chooses who will be part of their planning process as their support team. The Support Coordinator assists the participant in contacting the team members with the date(s) and time(s) of future planning meeting(s).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated;

(f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Linkage to support coordination through certification for waiver services takes up to 90 days. During the 90 day period, the following activities occur:

•Initial support coordinator (SC) contact with the participant
•The support coordinator contacts the participant/family to arrange a face-to-face meeting at a location requested by the participant/family. Virtual meeting may be allowed if criteria is met as defined in the OCDD Policy and Procedures manual. If a virtual meeting is held, electronic verification is acceptable.
•The support coordinator will schedule a time to assess the participant's needs utilizing the SIS/LAPLUS. This assessment, coupled with the person-centered planning process will be used to determine which OCDD waiver meets the needs of the participant and that is the one that is offered.
•The POC is developed through a person centered process that includes the participant and whomever the participant chooses which could include family, vocational providers, and whomever makes up the support team for the participant.
•The approvable POC must be approved within 90 days after linkage. An exception to this timeline will be made if the participant files an appeal as to the results of the SIS/LA Plus assessments which determines the OCDD Waiver offered, or if housing cannot be secured with a reasonable time period.
•The LGE staff have ten working days in which to review the POC information, complete the precertification home visit and approve the POC prior to waiver services beginning. If Medicaid eligibility is delayed, then the LGE has 5 days from the date of receipt of the Medicaid eligibility determination to approve the POC. Waiver services cannot begin prior to the approved POC.
•The entire team meets at least annually or as needed to review and revise the POC for the upcoming service year.

b. INITIAL ASSESSMENTS

The Office for Citizens with Developmental Disabilities (OCDD) has developed the “Guidelines for Support Planning” as a framework for all activities related to the person centered planning process for individualized supports and services. The needs-based assessments described below are completed within the discovery process for all applicants who have received an OCDD waiver offer and to identify the individual’s service needs. Discovery activities include:

1. A review of the participant’s records relevant to service planning (i.e. school, vocational, medical, and psychological records).
2. Conducting a personal outcomes assessment, which assists in determining what is important to the participant and his/her satisfaction or dissatisfaction with different life domain areas.
3. The completion and review of the Supports Intensity Scale (SIS) and Louisiana PLUS (LA PLUS) assessments.
a. The Supports Intensity Scale (SIS) is a standardized assessment tool designed to evaluate the practical support requirements of people with developmental disabilities. The SIS measures support needs for 85 different activities in the areas of home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy. The SIS then rates each activity according to frequency, amount, and type of supports needed.
b. The Louisiana PLUS (LA PLUS) is a complimentary assessment tool designed to identify support needs and related information not addressed by the SIS. The LA PLUS is used to evaluate a person’s support needs based on information and data collected from four areas of the person’s life, including:
I. Other support needs; material supports; hearing-related supports; supports for communicating needs; and stress and risks factors.
ii. Living arrangements
iii. Medical and diagnostic information
iv. Personal satisfaction reports; supports at home; work/day programs; living environment; family relationships; and social relationships.
4.A review and/or completion of any additional interviews, observations, or other needed professional assessments (i.e. occupational therapist, physical therapist, or speech therapist assessments).

Information obtained through the discovery process is shared with the support team in preparation for the POC meeting. Discovery activities are summarized and conclude with the POC meeting.

Based on the findings of the discovery activities described above, a determination is made as to which OCDD waiver is offered and a POC is developed.

The participant or his/her representative may request a reconsideration and present supporting documentation if he/she disagrees with the results of the initial needs based assessment and person-centered planning process which is used to

determine the OCDD waiver that is offered. If the participant disagrees with the reconsideration decision, he/she may request a fair hearing through the formal appeals process (Louisiana Department of Health, Division of Administration Law (DAL) process as referenced in Appendix F-1, Opportunity to Request a Fair Hearing).

c. REASSESSMENTS

A reassessment may be conducted at any time, particularly with a significant life change, but must be completed at least annually. The reassessment process is intended to be ongoing and designed to reflect changes in the participant's life, needs, and personal outcomes, inclusive of his/her preferences. The Support Coordinator and the participant/family, and others the participant/family chooses to be present, review the POC to determine if the goals identified on the POC are being achieved, the participant's/family's needs, including health and welfare are being addressed, and to make any adjustments or changes to the plan as necessary. Additionally, SIS/LA Plus assessment completed at waiver entry is reviewed to ensure continued accuracy. If significant changes are needed, the SIS/LA Plus is revised.

The participant or his/her representative may request a reconsideration and present supporting documentation if he/she disagrees with the specific OCDD waiver offered as a result of the initial needs based assessment and person-centered planning process. If the participant disagrees with the reconsideration decision, he/she may request a fair hearing through the formal appeals process (Louisiana Department of Health, Division of Administration Law (DAL) process as referenced in Appendix F-1, Opportunity to Request a Fair Hearing).

d. HOW PARTICIPANTS ARE INFORMED OF AVAILABLE SERVICES

The support coordinator informs the participant and his/her authorized representative of all available waiver and non-waiver services during the initial contact with the support coordination agency, in quarterly meetings as needed, on an annual basis during the POC development process, and as requested.

e. INCORPORATION OF PARTICIPANT GOALS/NEEDS/PREFERENCES IN PLAN

The following components are designed to incorporate the participant's goals, needs, and preferences in the person centered POC:
1. Discovery, which involves gathering information about the participant's interests, goals, preferences, and support needs through assessments and interviews. The discovery process ends with the formulation of the participant's vision and goals.
2. Planning. This involves using the information from the discovery process to develop the POC. During the planning process, the support team works with the participant to develop strategies to assist him/her in achieving his/her goals and support needs. Strategies should identify all supports needed to assist the participant in achieving his/her goals and meeting other identified support needs and an appropriate action plan. For each personal outcome/goal identified, the support team will identify the following: the participant's strengths, skills, abilities that can be used to achieve his/her goals; challenges, barriers, health issues, or risk factors that can be deterrents to meeting his/her goals; strategies, treatments, or trainings which can be implemented to overcome barriers; any opportunities available for increasing the participant's independence in achieving his/her goals.
3. Implementation, which involves the completion of noted strategies and provision of needed supports according to the participant's plan.
4. Review, which involves assessing if implementation occurred as planned and if positive changes have occurred as a result of the plan. The support team will assess the effectiveness of the strategies implemented and changes will be made as needed.

f. COORDINATION OF SERVICES
The person centered planning process requires the identification and utilization of all appropriate supports available to the participant prior to the support team considering waiver services.
Services are coordinated through the participant's support coordinator. The support coordinator takes the lead in guiding the support team in developing a POC that the participant is driving through the person centered process. The POC must include the following required components:
1. The participant's prioritized personal goals and specific strategies to achieve or maintain his/her desired personal goals. These strategies will focus first on the natural and community supports available to the participant and, if needed, paid services will be accessed as a supplement to natural and community supports.

2. An action plan which will lead to the implementation of strategies to achieve the participant's personal goals, including action steps, review dates, and the names of the persons who are responsible for specific steps.
3. Identified barriers, including health and safety risks, and specific strategies with timelines and the persons assigned to specific responsibilities, to address each issue.
4. All the services and supports the participant receives, regardless of the funding source which may include natural support networks, generic community services, and state plan services.
5. Identification of the frequency and location of services through a daily and alternate schedule.
6. Identification of providers and specification of the service arrangement.
7. Identification of the support team members who will assist the support coordinator in the planning process, as well as building and implementing supports for the participant.
8. Signature of all support team members present in the planning meeting to indicate their agreement with the service plan.

g. ASSIGNMENT OF RESPONSIBILITIES TO IMPLEMENT AND MONITOR PLAN
Each participant's POC includes multiple strategies and actions to achieve his/her life vision and goals, while addressing key support needs. The support team is responsible for:
1. Identifying any necessary training the participant or their family or staff need in order to implement the actions and strategies described in the POC and determining who will provide the necessary training.
2. Identifying any resources needed by the participant or their family or staff to implement the actions and strategies described in the POC and determining who will provide or acquire the needed resources.
In addition, the support coordinator is required to make a monthly contact with the participant and visit the participant once per quarter to monitor the implementation of the POC, the participant's satisfaction with services, and to determine if the participant has any new interests, goals, or needs. The quarterly visit should occur where services are being delivered so the support coordinator can observe service delivery.

The Support coordinator is responsible for reviewing the information on the POC, tracking progress on identified goals and timelines, and obtaining updated information on the participant's natural supports. This includes monitoring how individual providers (e.g. vocational) implement their portion of the participant's POC so that all relative goals and objectives are achieved.

During the quarterly monitoring reviews, the support team will review various data sources related to the participant's goals and objectives in order to determine if progress has been made.

h. HOW AND WHEN PLAN IS UPDATED
At least quarterly, the support team meets to review the POC to determine if the participant's goals have been achieved, if the participant's needs are being met, and to make any adjustments to the POC as needed or requested by the participant.

The POC must be updated at least annually or as necessary to meet the participant's needs. The completed, updated, annual POC must be submitted to the Support Coordination supervisor or LGE as defined in OCDD policy for approval. To be considered timely, the plan of care must be approved prior to the expiration of the previous plan of care.

OCDD uses the Guidelines for Support Planning, Chapter 9, Review and Modification of the Participant's Support Plan for HOW AND WHEN PLAN IS UPDATED.

At any time that the participant, support coordinator or any other support team member identifies a condition related to the participant's health status, behavioral change, or any other type of change which is not satisfactorily addressed or which requires updated discussion or planning, the support coordinator will immediately reconvene the support team to revise the POC to reflect the participant's revised needs and desired outcomes. This change in the participant's condition or health status, behavior or other change may or may not have been identified through re-assessment of the SIS and LA PLUS but may have recently surfaced, been identified through the participant's primary care physician, or been identified through periodic monitoring.

Emergency revisions must be submitted by the support coordinator to the Support Coordination supervisor or LGE as defined in OCDD policy within twenty-four (24) hours or by the next working day for approval. Revisions that include routine changes, such as planned vacations, must be submitted by the support coordinator at least seven (7) working days prior to the change.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Information from various assessments conducted during the planning process is used to identify any potential risks, which are then addressed through mitigation strategies that are included in the Plan of Care (POC).
In addition, information gained during interviews with the participant and his/her legal representatives and support team members, as well as information from the LGE pre-certification visit is also used during the initial planning process to identify potential risks to the participant.
•The participant and all support team members are given informed choice regarding the inclusion of any strategies recommended to be included in an initial or revised POC. The initial or revised POC with the included strategies must be signed and dated by all support team members.
•Recommendations from support team members on strategies to mitigate specific risk are incorporated into the POC. The LGE reviews recommendations, makes additional recommendations, and/or refers the issue to the OCDD State Office for input prior to approval of an initial or revised POC.
The direct service provider is responsible for completing an emergency evacuation plan and back-up support or staffing plan for each participant. Both are submitted to the Support Coordinator during the POC development process. The Support Coordinator is responsible for submitting the back-up plan and emergency evacuation plan to the Support Coordination supervisor or LGE as per OCDD policy, along with the participant's POC. The Support Coordinator supervisor or LGE ensures that the back-up plan and emergency evacuation plan are in place and will not approve the POC without these documents.
BACK-UP STAFFING PLANS
•All enrolled providers of waiver services must possess the capacity to provide the support and services required by the participant in order to insure the participant's health and safety as outlined in the POC, and are required to have functional Individualized Back-Up plans consistent with the participant's POC. When paid supports are scheduled to be provided by an enrolled provider of waiver services, that provider is responsible for providing all necessary staff to fulfill the health and safety needs of the participant.
•The identified enrolled provider of waiver services cannot use the participant's informal support system as a means of meeting the agency's individualized back-up plan, and/or emergency evacuation response plan requirements unless requested by and agreed to by the participant/family.
•The identified enrolled provider of waiver services must have in place policies and procedures that outline the protocols the agency has established to assure that back-up direct support staff are readily available, lines of communication and chain-of-command have been established, and procedures are in place for dissemination of the back-up plan information to participants, their legal representatives, and Support Coordinators.
•It is the identified enrolled provider of waiver services responsibility to develop the back-up plan and provide it to the Support Coordinator in a time frame that will allow it to be submitted for review/approval as a part of the POC.
•The Support Coordinator is responsible for working with the participant, his/her family, friends, and providers during initial and subsequent POC meetings to establish plans to address these situations.
•The Support Coordinator assists the participant and the support team members to identify individuals who are willing and able to provide a back-up system during times when paid supports are not scheduled on the participant's POC.
•All back-up plans must include detailed strategies and person-specific information that addresses the specialized care and supports needed by the participant as identified in the POC. Back-up plans must be updated no less than annually to assure information is kept current and applicable to the participant's needs at all times.
•Support coordinators are to ensure that back-up and emergency evacuation plans are in place.
EMERGENCY EVACUATION PLANS
•An Emergency Evacuation Response Plan must be developed in addition to the individual back-up plan, be included in or attached to the participant's service plan, and reviewed a minimum of once each service year.

•The Emergency Evacuation Response Plan provides detailed information for responding to potential emergency situations such as fires, hurricanes, hazardous materials release, tropical storms, flash flooding, ice storms, and terrorist acts.
•The Emergency Evacuation Response Plan must include at a minimum the following components:
- Individualized risk assessment of potential health emergencies;
- Geographical and natural disaster emergencies, as well as potential for any other emergency conditions;
- A detailed plan to address participant's individualized evacuation needs;
- Policies and procedures outlining the agency's protocols regarding implementation of Emergency Evacuation Response Plans and how these plans are coordinated with the local Office of Emergency Preparedness and Homeland Security;
- Establishment of effective lines of communication and chain-of-command, and procedures for dissemination of Emergency Response Plan to participants and Support Coordinators; and
- Protocols outlining how and when direct support staff and participants are to be trained in Emergency Evacuation

Response Plan implementation and post-emergency protocols.
Training for direct support staff must occur prior to any worker being solely responsible for the support of the participant, and participants must be provided with regular, planned opportunities to practice the Emergency Evacuation Response Plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

On acceptance of the waiver offer, the data management contractor offers Freedom of Choice of Support Coordination agencies.

At initial contact and annually with the participant, the support coordinator discusses the provider freedom of choice form and the availability of all services. The support coordinator is responsible for offering Freedom of Choice of providers.

The support coordinator is responsible for advising the participant that changes in providers can be requested at any time, but only by the participant or personal representative. The support coordinator will facilitate any request for a change of all providers.

The support coordinator is responsible for maintaining a current listing of qualified providers

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Service plans are subject to approval by the State Medicaid Agency (SMA). The SMA does not review and approve all service plans prior to implementation; however, all are subject to SMA's approval. The SMA completes reviews of participant records on a routine basis. Information reviewed includes, but is not limited to: development of an appropriate individualized person-centered service plan, completion of updates and revisions to the service plan, and coordination with other agencies as necessary to ensure that services are provided according to the service plan. Medicaid Program Support and Waivers (MPSW) section staff has access to the Louisiana Support Coordination Application (LASCA) database which houses results of annual monitoring of Support Coordination Agency performance. These performance results include determinations of level of performance on service plan development, implementation, and service delivery. MPSW compares support coordination service plans and corresponding monthly Support Coordination Documentation (SCD) obtained from the support coordination agency with LASCA results to validate the support coordination monitoring process and to ensure participants' health and welfare. If discrepancies are identified, the Medicaid HCBS Oversight Committee addresses the discrepancies and determines actions necessary to resolve them on a systemic level, e.g. training or policy revision.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**

◉ **Every twelve months or more frequently when necessary**

○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

☐ **Medicaid agency**

☒ **Operating agency**

☒ **Case manager**

☒ **Other**

Specify:

Direct Service provider agency

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Support Coordinator is responsible for monitoring the implementation and effectiveness of the POC in meeting the participant's needs and preferences.

The Support Coordinator contacts the participant and his/her legal representative within 10 working days after the initial POC is approved to assure the appropriateness and adequacy of services delivery.

Support Coordinators make monthly contacts with each participant and/or his/her legal representatives. One contact per quarter must be a face-to-face with the participant. A Virtual meeting may be allowed if criteria is met as defined in the OCDD Policy and Procedures manual. If a virtual meeting is held, electronic verification is acceptable. The support coordinator may make unannounced visits to verify that the participant is receiving the services based on the schedule of the approved POC.

During these contacts the Support Coordinator checks to make sure that:
• There is access to waiver and non-waiver services identified in the POC, including access to health services;
• The strategies to meet the participant's personal goals are being implemented and the effectiveness of the strategies;
• The services outlined on the POC are meeting the needs of the participant;
• The participant is satisfied with the service providers he/she has chosen;
• Services are being furnished in accordance with the POC;
• The participant's health and welfare needs are being met; and
• Back-up plans, if utilized, are effective and persons identified as responsible for back-up plans are still active in the participant's life.

Information from Support Coordinator's monitoring is maintained at the Support Coordination Agency's physical office. Support Coordinators must refer any findings during contacts or visits that appear to be out of compliance with federal or state regulations, and OCDD policies to the LGE for review and recommendations. If the finding cannot be resolved at the LGE level, it will be referred to the OCDD State Office to be resolved.

Revisions to the POC reflect the results of the monitoring. During the monitoring of POC implementation, if changes are needed a revision to the POC will be completed. All revisions must be reviewed and prior approved by the Support Coordinator supervisor or the LGE per OCDD policy. Emergency revisions to the POC must be submitted to the Support Coordinator supervisor or LGE within 24 hours or next business day. Routine revisions must be submitted to the Support Coordinator supervisor or LGE at least seven (7) days prior to the change.

If a participant receives a denial, reduction or termination of services, the denial must be sent to the LGE to ensure appeal information is provided to the participant/authorized representative as outlined in Appendix F, section F-1.

b. Monitoring Safeguards. *Select one:*

- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
D.a.i.a.1. Number and percentage of plans of care in which services and supports align with the participants' assessed needs. Percentage = Number of plans of care that meet the assessed needs of waiver participants / Total number of plans of care reviewed in the sample.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.a.i.a.2. Number and percentage of plans of care in which services and supports align with the participant's assessed risk. Percentage = Number of plans of care that meet the assessed risks of waiver participants / Total number of plans of care reviewed in the sample.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

Agency		
☒ **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:

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

Performance Measure:
D.a.i.a.3. Number and percentage of plans of care that address participants' personal goals. Percentage = Number of plans of care that address participants' personal goals / Total number of plans of care reviewed in the sample.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

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

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

Performance Measure:

D.a.i.c.2 Number and percentage of participants whose plans of care were reviewed and revised to address changing needs. Number of plans of care revised to address changing needs/total number of participants whose quarterly contact indicated a changing need.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
D.a.i.c.1. Number and percentage of annual plans of care received prior to the expiration date of the approved plan of care. Percentage = Number of annual plans of care received by due date / Total number of plans of care due during reporting period.

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

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

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

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

Performance Measure:
D.a.i.d.2 Number and percent of participants who received services in the scope, amount, frequency and duration specified in the plan of care. Numerator = Number of participants who received services in the scope, amount, frequency and duration specified in the plan of care; Denominator = Total number of participants.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
D.a.i.d.1. Number and percentage of participants who received all types of services specified in the plan of care. Numerator = Number of participants who received all types of services specified in the plan of care; Denominator = Total number of participants

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

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

Medicaid Data Contractor		
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

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

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

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

Performance Measure:
D.a.i.e.2. Number and percentage of waiver participants with a valid signature, defined as the participants/authorized representative's signature, on the plan of care which verifies that available services were discussed with the waiver participants. Percentage = Number of participants with a valid signature on the plan of care/ Number of participants reviewed in the sample.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
D.a.i.e.1. Number and percentage of waiver participants with a valid signature, defined as the participant's/authorized representative's signature, on the plan of care which verifies that the freedom of choice was offered among waiver providers. Percentage = Number of waiver participants with a valid signature on the plan of care/ Total number of participants reviewed in the sample.

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

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

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

Data Aggregation and Analysis:

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

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

ii. For all performance measures except D.a.i.c.1(Updated prior to plan expire), D.a.i.d.1, and D.a.i.d.2, OCDD LGE staff perform monitoring of support coordination agencies at least annually utilizing the OCDD Support Coordination Monitoring Tools: Participant Interview, Participant Record Review, Support Coordinator Interview, and Agency Review. The sample size will be large enough for a confidence level of 95% + or – 5%. The number of participants from the statewide sample to be included in each support coordination agency (SCA) sample will be proportional to the percentage of participants linked to each agency on the date the sample is generated. An SCA's sample size will be determined separately for each region in which the SCA operates.

For all performance measures except D.a.i.c.1, D.a.i.d.1 and D.a.i.d.2., the specific criteria for these measures are found in the OCDD Interpretive Guidelines for the OCDD Participant Record Review with a parallel set of guidelines entitled "Guidelines for Support Planning" for support coordinators.

D.a.i.c.1 measures the first part of sub-assurance c., whether the service plan was updated at least annually. The Medicaid Data contractor is responsible for prior authorization of services and authorizes services based up receipt of an approved service plan. Data is then entered into the contractor data system which provides 100% representativeness for this measure.

D.a.i.c.2 measures the second part of sub-assurance c., whether service plans are updated when warranted by changes in the waiver participant's needs. The data source is the OCDD Participant Record Review and the responsible party for data collection/generation is the LGE.

D.a.i.d.1, and D.a.i.d.2: the Medicaid data contractor prior authorizes services according the approved service plan and enters post authorization of service once a provider has verified service delivery. This data is utilized to determine whether the participant received the type, scope, amount, duration, and frequency specified in the service plan. The method for validating this information is collected by the Support Coordination Agency during the quarterly reviews in the home and entered into the Case Management Information System (CMIS) which is accessed by the Medicaid Data Contractor to validate if the services have been delivered in the type, amount, frequency, duration, of services identified in the plan of care. The Support Coordination Agency and the LGE review the data quarterly for these measures.
Regarding D.a.i.e.1 and D.a.i.e.2, a valid signature on the service plan is either the signature of a participant with the capacity to approve the plan or a person who has been designated on the OCDD Authorized Representative Form as such.

b. Methods for Remediation/Fixing Individual Problems

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

The State's method for addressing individual problems identified through performance measures D.a.i.c.1., D.a.i.d.1., D.a.i.d.2 is as follows:

D.a.i.c.1: The LGE receives quarterly reports from the Medicaid Data Contractor for review. If the participant's annual Plan of Care (POC) was not submitted within the required timeline, the LGE will contact the support coordination agency. The support coordination agency will have 10 days to respond identifying why the plans of care were not timely submitted. Depending upon the scope and persistence of such problems, OCDD may pursue sanctions as outlined in the Support Coordination Performance Agreement including withholding payment.

D.a.i.d.1: The LGE receives quarterly reports from the Medicaid Data Contractor in order to review trends and patterns of under-utilization of services. If this appears to be an isolated event, the LGE will follow up with the support coordination agency to determine the reason and the support coordinator shall revise the POC as necessary. If the POC revision is not submitted within the timeframe, OCDD shall pursue sanctions as outlined in the Support Coordination Performance Agreement. If this appears to be widespread, the LGE will consult with OCDD State Office who will then bring the issue to the Performance Review Committee and the OCDD Executive Management team for review and resolution.

D.a.i.d.2: The LGE receives quarterly reports from the Medicaid Data Contractor in order to review trends and patterns of under-utilization of services. If the LGE discovers under-utilization due to a particular agency, among certain services, lack of availability of services, etc., the LGE will consult with OCDD State Office who will then bring the issue to the Performance Review Committee and the OCDD Executive Management Team for review and resolution.

The State's method for addressing individual problems identified through the remaining performance measures is as follows: LGE staff perform monitoring of Support Coordinator Agencies (SCA) at least annually utilizing the OCDD Support Coordination Monitoring Tools: Participant Interview; Participant Record Review; Support Coordinator Interview; and Agency Review. The processes for scoring and determining the necessity for corrective actions are located in the "Updated Guidelines for Scoring, Corrective Action and Follow-up Monitoring." After all elements are assessed and scored, the LGE reviewer documents the findings, including the Statement of Determination which delineates every POC remediation required and required responses/plans of correction expected from the SCA. Based on the scope and severity of findings, the SCA is assigned a Statement of Determination at Level I, Level II, or Level III. The LGE and/or State Office follow-up according to timelines associated with each level to ensure that plans of correction are implemented and effective. Level III determinations are those having the actual or potential for immediate jeopardy. In these cases, the SCA must develop a plan of correction that includes the identification of the problem; full description of the underlying causes of the problem; actions/interventions that target each underlying cause; responsibility, timetable, and resources required to implement interventions; measurable indicators for assessing performance; and plans for monitoring desired progress and reporting results. In addition, OCDD takes enforcement action to assure the health and safety of participants. Actions include, but are not limited to: transfer of participants who are/may be in jeopardy; removal of SCA agency from the freedom of choice list; suspension of all new admissions; financial penalties; suspension of contract/certifications as a provider of SC services.

If a Plan of Correction, Progress Report and/or Follow-up Report remains unapproved by the time of the next annual review the agency placed on the next level with more stringent requirements. With a finding of satisfactory or a recommendation for improvement no remediation is required. These remediation activities will be documented through tracking events in the Support Coordination Monitoring database.

Training will be necessary when trends are detected in plans of care that do not address: participant goals, needs (including health care needs), and preferences; how waiver and other services are coordinated; and identification of responsibilities to implement the plan. The training requirements depend on the Support Coordination Monitoring findings and are based on the criteria found in OCDD Interpretive Guidelines for the OCDD Participant Record Review with a parallel set of guidelines entitled "Guidelines for Support Planning" for support coordinators.

An unsatisfactory plan of care is one with criteria "not met" according to the OCDD Interpretive Guidelines for the OCDD Participant Record Review and parallel set of guidelines entitled "Guidelines for Support Planning" for support coordinators.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied,

suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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

Both applicants and participants are afforded the right to request a fair hearing for services which have been denied, not acted upon with reasonable promptness, suspended, terminated, reduced or discontinued, La. R.S. 46:107. In accordance with La. R.S. 28.454.16, a person may file an administrative appeal to the Division of Administrative Law - LA Department of Health Section regarding the following determinations:

1) A finding by the office that the person does not qualify for system entry;
2) Termination of a support or service;
3) Discharge from the system; and/or
4) Other cases as stated in office policy or as promulgated in regulation.

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

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

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

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

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

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

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

Louisiana Administrative Code Title 48, Part I, Subpart 3, Chapter Home and Community Based Service Provider Licensing Standards, Subchapter C, Admission, Transfer and Discharge Criteria, require that enrolled providers of waiver services provide participants and their legal representatives notice in writing at least thirty days prior to the transfer or discharge from the provider agency with the proposed date of the transfer/discharge, the reason for the action, and the names of personnel available to assist the participant throughout the process. The enrolled provider of waiver services must also provide the participant and his/her legal representatives with information on how to request an appeal of a decision for involuntary discharge. A copy of the notice of intent to transfer/discharge, and information that was provided on how to access the appeal process is kept in the participant's record at the enrolled provider of waiver services' physical location of business.

All Administrative Hearings are conducted in accordance with the Louisiana Administrative Procedure Act, La. R.S. 49:950 et seq. Any party may appear and be heard at any appeals proceeding through an attorney at law or through a designated representative.
Fair Hearing regarding dental services reference LA.0005.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

LDH Health Standards Section is responsible for receiving, responding to and determining the necessity of and/or scope of investigation for all complaints in which the allegations involve potential non-compliance of Home and Community Based (HCBS) licensing standards by the direct service provider.
The LGEs are responsible for receiving, reporting, and responding to complaints received for individuals supported through the waiver in which the allegations involve alleged violations of waiver policy by the direct service provider and/or non-regulatory matters that are not handled by Health Standards.

Reference la.0005 for dental benefit plan grievance system.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Office for Citizens with Developmental Disabilities (OCDD) is responsible for receiving, reporting and responding to customer complaints received for people supported through their office including those supported through the SW in which the allegations involve alleged violations of waiver policy by the direct service provider and/or non-regulatory matters that are not handled by Health Standards. A complaint is a concern, dissatisfaction, or dispute expressed through written or verbal communication or expressed through other means, such as assistive devices, regarding: care, supports and services, action or inaction of staff, department or agency requirement, regulation or policy or other circumstances affecting quality of care or quality of life, including allegations of rights of violations. Each OCDD entity including LGEs or State Office are responsible for receiving, reporting, and responding to customer complaints. Each OCDD entity is responsible for training their staff, participants, their families, and providers regarding OCDD's policy on complaints. A complaint may be made in person or by phone, fax, e-mail or mail to an OCDD entity. When a complaint is received by an OCDD entity the complaint is reviewed to determine if the complaint can be resolved by OCDD or if the complaint needs to be referred to another agency (Bureau of Health Services Financing, Protective Services, etc.) for action/resolution. The initiation of the complaint review and follow-up occurs within two business days of receipt of the complaint. Actions to resolve the complaint will be completed within fifteen calendar days of receipt of the complaint, unless an extension is granted. A written response describing the actions in response to the complaint, is mailed to the complainant within five (5) business days of the complaint resolution/action. OCDD entities will continue to follow up with other agencies regarding complaint action/resolution. All complaints are entered into a database for tracking of complaints and quality management purposes.

Each OCDD entity will utilize complaint data from the complaint database to conduct quality reviews. A sample size of complaints is reviewed based on the number of complaints received and resolved each quarter. The reviews shall include contacting the complainants to assure their satisfaction with the resolution. The reports generated from the complaints database shall be evaluated to identify trends and patterns for determining appropriate strategies for improving services. OCDD State Office shall conduct oversight activities to assure that OCDD entities comply with policy guidelines. At least five percent of the total complaints from OCDD entities are reviewed quarterly to assess whether the complaints were addressed according to requirements. Reports are evaluated to identify trends and patterns and to make recommendations for training, technical assistance or strategies for improving services

The Health Standards Section (HSS) is responsible for the operation of grievance/complaints that involve the potential non-compliance of Home and Community Based licensing standards by the direct service provider.

• The HSS State Office maintains a toll free complaint line for receipt of complaints involving waiver participants as well as other home and community based services such as those provided through Medicaid State plan.

• The nature and scope of the complaint is at the discretion of the individual registering the complaint.

• The Health Standards toll free complaint line number, the LGE complaint line number and the number for protective services is printed on business cards, brochures, and fact sheet along with directions on what number to call depending upon the allegations being reported. It is given to participants and their legal representative(s) at intake by their support coordinator. During the pre-certification visit the LGE staff checks to make sure that the information has been given to them. The support coordinator reviews the information during quarterly face to face visits, and each year at the annual service plan team meeting, or whenever it is requested by the participant and his/her legal representative(s). A virtual meeting may be allowed if criteria is met as defined in the OCDD Policy and Procedures manual. If a virtual meeting is held, electronic verification is acceptable.

• HSS and LGE staff, as well as support agencies such as Families Helping Families distribute the HSS, LGE and protective services contact information when assisting participants and their legal representative(s). Direct service providers are also required to give the toll free numbers to all participants.

• Support coordinators are responsible for informing participants and their legal representative(s) initially, annually or whenever information about the system is requested that filing a grievance or complaint is not a pre-requisite or substitute for a Fair Hearing. LGE staff checks to make sure that this information has been relayed to them during the pre-certification visit.

• If LGE or State Office Staff is contacted by a participant/legal representative (s), other state agency, support coordinator or provider wishing to file a complaint, the entity staff will review and consider the information provided by the complainant and make a determination as to whether the complaint can be resolved by the LGE or whether additional action is required by HSS. If it is determined that there is evidence of non-compliance of the HCBS Licensing Standards, the LGE will refer the complainant to the HSS Complaint line within 24 hours.

• HSS and the LGE triages all complaints in the following manner:

- Provider non-compliance licensing issues are resolved by HSS.
- Complaints identified as abuse, neglect, exploitation or extortion are referred immediately to the applicable protective services agency.
- All other types of complaints are referred to OCDD State Office for incident resolution. Complaints identified as critical events or incidents are investigated by the appropriate office within thirty days of receipt of such report.

• Pursuant to Louisiana Revised Statutes 40:2009.14 if the complaint involves provider non-compliance with HCBS licensing standards, HSS will investigate by on site visit or administrative desk review. A written report is sent to the complainant within 45 days of receipt of the completed investigation, if a response to the complaint is requested by the complainant.

Reference la.0005 for dental benefit plan grievance system.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Critical events or incidents that are required to be reported as required by Louisiana Revised Statute 14:403.2, which defines reporting criteria pertaining to any known or suspected abuse, neglect, exploitation or extortion, by the discoverer of the incident immediately upon discovery to the appropriate protective services agency for review and follow-up action are:

- •Abuse (adult), as defined in Louisiana Revised Statute15:503.
- •Abuse (child), as defined in Louisiana Children's Code, Article 1003.
- •Exploitation (adult), as defined in Louisiana Revised Statute15:503.
- •Extortion (adult), as defined in Louisiana Revised Statute 15:503.
- •Neglect (adult), as defined in Louisiana Revised Statute 15:503.
- •Neglect (child), as defined in Children's Code, Article 1003.

The following categories of incidents as defined in OCDD Operational Instruction #F-5: Critical Incident reporting, Tracking and Follow-up Activities for Waiver Services are required to be reported in the LDH incident reporting system by the provider :

- •Death
- •Fall
- •Involvement with Law Enforcement
- •Loss or Destruction of Home
- •Major Behavioral Incident
- •Major Illness
- •Major Injury
- •Missing
- •Restraint Use
- •Medication Errors

The provider must verbally notify the support coordinator of a critical incident as soon as possible after taking all necessary actions to protect the participant from further harm and responding to the emergency needs of the participant. The provider must submit a written critical incident report via the LDH incident reporting system by the next business day after incident discovery.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The state provides information to the participant, his/her family, legal representative or authorized representative during initial waiver planning/certification and annually thereafter.

Abuse, neglect and exploitation is discussed with the participant and/or families or legal representative initially by the support coordination agency, the local governing entity, and the provider agency. During the initial planning process, participants receive information regarding their right to be free from abuse, neglect and exploitation and how to report. Each participant receives a copy of the OCDD Participant Rights and Responsibility form which contains the phone number to the Health Standards Complaint line as well as the phone number to the different protective services agencies. (Elderly Protective Services (EPS), Adult Protective Services (APS) or Child Protected Services. CPS).

During the annual plan of care meeting process, the OCDD Rights and Responsibilities form is reviewed and discussed, which includes a conversation regarding abuse, neglect, and exploitation. A copy of the OCDD Rights and Responsibilities form is given to the participant/family and is retained in the home. The form contains the phone number to the Health Standards Complaint line as well as the phone number to the different protective services agencies. (Elderly Protective Services (EPS), Adult Protective Services (APS) or Child Protected Services. CPS).

Additionally, on a quarterly basis, the Support Coordinator is required to conduct a face to face visit with the participant (and/or families or legal representatives as appropriate). As part of the visit, the Support Coordinator ensures that the Health Standards Complaint line number as well as the other protective services agencies are available to the participant. Any complaint called into the Health Standards complaint line that constitutes abuse, neglect, or exploitation results in a complaint being generated by Health Standards and routed to the appropriate agency (Elderly Protective Services (EPS), Adult Protective Services (APS) or Child Protected Services. CPS).

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

When a critical incident occurs, the following actions are taken:
Provider:
• Takes immediate action to assure that the participant is protected from further harm and must respond to any emergency needs of the participant. The provider must review each critical incident and record remedial actions taken in response to the incident within twenty-four (24) hours of the discovery of the incident, including reports made to protective services or law enforcement.
•Enters critical incident report information into the incident reporting system by close of business the next business day after notification of a critical incident;

•Cooperates with the appropriate protective service agency once an investigation commences if abuse/neglect/exploitation/extortion is reported. Supplies relevant information, records, and access to members of the agency conducting the investigation.
•Participates in planning meetings to resolve each critical incident or to develop strategies to prevent or mitigate the likelihood of similar incidents in the future.
•Tracks critical incidents and outcomes in order to identify remediation needs and quality improvement goals and to determine the effectiveness of strategies employed for incident resolution.

Support Coordinator:
•Monitors critical incidents entered into the incident reporting system by the provider on a daily basis;
•Contacts the DSP within two (2) hours of discovery if the incident is discovered by the Support Coordinator,
•Reports incidents involving abuse, neglect, exploitation, and extortion to Protective Services.
•Enters follow-up case note by close of the sixth (6th) business day after initial report;
•Continues to follow up with the DSP agency, the participant, the participant's family or natural supports, the LGE waiver office and any other entities involved, as necessary, and updates in the incident reporting system with case notes until the incident is resolved and the case is closed;
•Submits to the LGE waiver office a request for extension of open case in circumstances defined in OCDD Operational Instruction F-5;
•Convenes any planning meetings that may be needed to address remediation of the critical incident or develop strategies to prevent or mitigate the likelihood of similar critical incidents occurring in the future, and revise the POC accordingly;
•Conducts final supervisory review and closure of critical incidents within thirty (30) calendar days in the categories specifically authorized in OCDD Operational Instruction F-5, excluding incidents of death, abuse, neglect or risk management incidents that have crossed the threshold for referral to OCDD Clinical Review Committee as defined in OCDD Operational Instruction F-5.
•Sends the participant and DSP a copy of the Incident Participant Summary within fifteen (15) days after support coordinator or LGE waiver office final supervisory review and closure. The Summary will not include the identity of the reporter or any sensitive or unsubstantiated allegations. The Participant Summary is not distributed in the event of deaths;
•For transfer of open cases, the transferring support coordination agency must supply the accepting support coordination agency with the incident number(s) at the time of transfer of records. Additionally, the transferring support coordination agency must notify the accepting LGE waiver office. The accepting agencies must review, assign, take actions to resolve the incident, and enter into the case record in the incident reporting system until closure of the incident.
•Tracks trends and patterns of critical incidents to identify remediation needs and quality improvement goals and to determine the effectiveness of strategies employed.

Local Governing Entity (LGE):
•Reviews all new incoming critical incident reports in the incident reporting system on a daily basis, , and assigns incidents with categories specified in OCDD Operational Instruction F-5 (abuse, neglect, death, and missing person) to staff within 1 business day for monitoring /follow-up.
•Identifies critical incidents as defined in OCDD Operational Instruction F-8, Risk Management Process for Waiver Services: Critical Incident Reviews that have crossed threshold for any participant and refers cases to the OCDD Clinical Review Committee.
•Assures that all activities occur within required timelines as detailed in OCDD Operational Instruction F-5 and F-8;
•Provides technical assistance to the support coordinator when timelines are not being met or the support coordinator reports an inability to identify necessary resources. Assists in making referrals to additional referral resources as needed;
•Immediately reports the incident to the appropriate protective service agency if the LGE suspects or becomes aware that a critical incident meets the definition of abuse, neglect, exploitation or extortion, and there is no documentation that the allegation has been reported to the appropriate protective services agency;

•Conducts follow-up monitoring of a sample of critical incidents where remedial actions required revision of the plan of care;
•Closes critical incident cases for abuse, neglect, death, attempted suicide and missing person after all necessary follow-up has occurred and documented in the critical incident report, within thirty (30) days.
•Grants extensions to timelines for closure to open incidents in categories as permitted in OCDD Operational Instruction F-5.
• Tracks trends and patterns of critical incidents to identify systemic remediation needs and quality improvement goals and to determine the effectiveness of strategies employed.

Department of Children & Family Services/ Child Protective Services (DCFS/CPS): Investigates allegations or reports of abuse, neglect or exploitation by a family member or legal guardian involving a waiver participant aged 0-17 years, based upon CPS policies and guidelines,
•Develops a protective plan and retains the authority to remove the minor participant from the home setting for his/her safety. The LGE waiver offices will coordinate continued waiver services contingent on CPS plan of protection.

Office of Adult & Aging Services/Adult Protective Services (APS) Investigates allegations of abuse, neglect, exploitation, or extortion involving a participant aged 18-59 when the alleged perpetrator is a family member, legal guardian, or other natural support person not employed by a licensed provider agency, based upon APS policies and guidelines.
APS develops a protective plan and retains the authority to remove the participant from the home setting for his/her safety. The LGE waiver offices will coordinate continued waiver services contingent on APS plan of protection.

Elderly Protective Services (EPS):
Investigates allegations of abuse, neglect, exploitation and extortion involving a participant aged 60 or older when the alleged perpetrator is a family member, legal guardian, or other natural support person not employed by a licensed provider agency, based upon EPS policies and guidelines.
EPS develops a protective plan and retains the authority to remove the participant from the home setting for his/her safety. The LGE waiver offices will coordinate continued waiver services contingent on EPS plan of protection. Health Standards Section (HSS):
HSS investigates allegations or reports of abuse, neglect, exploitation, or extortion when the alleged perpetrator is a provider licensed agency owner or employee, based upon HSS internal policy and guidelines.
HSS determines the level of jeopardy to waiver participants, issues findings and deficiencies, and requires a plan of correction from the provider to remediate the conditions that caused the incident. The LGE and support coordination agency will coordinate waiver services contingent on the plan of correction.
Law Enforcement:
•The provider and support coordinator are required to ensure that they contact law enforcement in the event of any allegation of child abuse or neglect involving participants under the age of 18. Protective services contacts law enforcement in the event of a substantiated case of abuse or neglect according to their policies and procedures.
•In the event of a participant's arrest for a crime, the provider and support coordinator contact law enforcement to assure that information about the participant's health needs, medications or other risk factors are conveyed to assure safety while in police custody.
OCDD State Office:
•Provides technical assistance to LGEs when all attempts to mitigate harm have been exhausted;
•Collaborates with protective service agencies, Health Standards, law enforcement and the judicial system to assure coordination of activities to mitigate harm in individual cases;
•Monitors timely closure of critical incidents and adherence to OCDD critical incident operational instructions by the direct service providers, support coordinators and LGEs;
•Conducts Clinical Review Committee (CRC) case reviews for participants who experience repeated critical incidents as defined in OCDD Operational Instruction #F-8 Risk Management Process for Waiver Services: Critical Incident Reviews. CRC has the authority to issue recommendations for further action to providers, support coordination agencies and LGEs when it is discovered that practices by any one or combination of these entities have not sufficiently assured mitigation of potential harm. CRC may, at its discretion, request a follow-up report on progress towards mitigation within 60 day timeline;
•Conducts Mortality Review Committee (MRC) meetings to analyze deaths of waiver participants, as described in OCDD Operational Instruction #F-1 Mortality Review for Waiver Participants. MRC has the authority to issue a request for corrective action to providers, support coordination agencies and LGEs when it is discovered that practices by any one or combination of these entities could potentially affect other participants negatively. The MRC request for corrective action

can be issued in conjunction with corrective action plans issued by HSS.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

OCDD is the State entity responsible for overseeing the operation of the incident management system.
A multi-agency Memorandum of Understanding between OCDD and LGEs delegates the day to day responsibility for oversight of the reporting and response to critical incidents or events that affect waiver participants.
OCDD maintains the services of support coordination agencies through contracts that stipulate the requirements for compliance with waiver regulations.
OCDD State Office Quality Section analyzes trends and patterns in critical incident reports to identify potential quality enhancement goals and utilizes the critical incident data to determine the effectiveness of OCDD Quality Enhancement strategies.
OCDD provides the State Medicaid Agency with aggregate quarterly reports which are used to identify trends and patterns.
The State Medicaid Agency oversees the maintenance and continual upgrading of the on-line critical incident reporting system.
Frequency of oversight activities:
The LGE, on a monthly basis, will pull a sample of critical incidents to review for adherence to policy including a review to determine if all necessary actions were taken to address and resolve critical incidents and perform annual analysis of data to determine the effectiveness of quality enhancement goals and activities.
OCDD State Office and the LGEs jointly participate in the Human Services Accountability and Implementation Plan (AIP) to measure performance, report outcome measures and develop and implement quality enhancement strategies.
LGEs will report measures to OCDD quarterly and OCDD will conduct site visits to each LGE annually. The monitoring protocol and strategy for corrective action plans is described in OCDD Operational Instruction F-7: Quality Partnership: Reporting and Verification of Performance Measures and Quality Management Initiatives for Developmental Disability Services.
MPSW provides oversight and remediation enforcement of critical incident management through the Medicaid HCBS Oversight Committee which meets quarterly to review current performance reports for the all waiver assurances including health and welfare. Quality recommendations or issues which cannot be resolved at this level are placed on the agenda of the Medicaid/Program Offices Quarterly Meeting.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

LDH BHSF HCBS Providers Minimum Licensing Standards(LAC 48:I.Chapter 50)§5029 establishes prohibitions to the use of chemical, physical & mechanical restraints,seclusion or any procedure which denies food, drink, visits with family,or use of rest room facilities. Enrolled providers of waiver services are required to ensure that non-intrusive positive approaches to address the meaning/origins of behaviors are used prior to the development of a restrictive plan,& cover any behavioral emergency & provide documentation of the event in an IR format. Restraint is a reportable CI as described in OCDD OI F-5: Critical Incident Reporting, Tracking & Follow-up Activities for Waiver Services.
•If a protective hold must be used,DSP staff will notify the SC verbally no later than 2 hours after the incident or discovery of the incident & report in writing via CIR system within 24 hours,following appropriate reporting procedures.
Restraint:any physical, chemical,or mechanical intervention used to control acute,episodic behavior that restricts movement or function of the person or a portion of the person's body must be reported as a CI.
Restraint use categories:
•Behavioral:restraints used to suppress a person's behavior & don't include restraints used when conducting a medical treatment. May be planned or unplanned. May involve personal, mechanical,or chemical restraints. Includes a protective hold.
•Medical:restraints applied as a health related protection that are prescribed by a licensed physician,licensed dentist,or licensed podiatrist.Used when absolutely necessary during the conduct of a specified medical or surgical procedure or when absolutely necessary for the protection of the person during the time that a medical condition exists. May be planned or unplanned. May involve personal, mechanical,or chemical restraints. The appropriate use of "light sedation" is not considered a medical restraint.
The OCDD provides MPSW with aggregate data & reports which are inclusive of any reported restraint use.
•Enrolled providers are prohibited by licensing regulations to inflict corporal punishment,use chemical restraints, psychological abuse,verbal abuse,seclusion,forced exercise,mechanical restraints,& any procedure which denies food, drink,or use of rest room facilities and any cruel, severe, unusual or unnecessary punishment.
•The only restraint that may be used in an emergency is a protective hold (falls under the definition of a behavioral restraint).
•Protective holds are only to be used in an emergency to prevent a person from causing harm to self or others & after other, less restrictive interventions/strategies have failed. Protective holds may only be implemented by trained staff & of short duration. OCDD has a Policy on Restraint & Seclusion #701 issued 3/6/03.
•Individual right to be free from restraints imposed for the purpose of coercion,discipline or convenience of or retaliation by staff;
•When restraints are necessary in an emergency situation where the behavior of the individual represents an imminent risk of injury to the individual or others;
•Staff training & competence in methods for minimizing the use of restraint & safely applying restraint & in policies concerning the use of restraint.
•Enrolled providers are required by licensing regulations to ensure that non-intrusive, positive approaches to address the meaning/origin of behaviors that could potentially cause harm to self or others.
•DSP staff are required to have initial & annual training in the management of aggressive behavior, this includes acceptable & prohibited responses, crisis de-escalation,& safe methods for protecting the person & staff, including techniques for physically holding a person if necessary. When a participant becomes angry, verbally aggressive or highly excitable, staff will utilize this training.
•If a protective hold must be utilized, direct care staff will notify the SC verbally immediately or within 2 hours of discovery & report in writing via CIR within 24 hours following appropriate reporting procedures.
•The SC will contact the participant & his/her legal representatives within 24 hours of receiving the CIR involving a physical hold. Changes to the POC or living situation will be considered to support the person's safety & well-being. Follow-up visits with the participant & his/her legal representatives are conducted & include questions about any actions taken by a DSP that may qualify as unauthorized use or misapplication of physical restraints.
•Unauthorized use of restraints is detected through the licensing & surveying process that HSS conducts as a result of the SC's monthly contacts with participants & their legal representative(s),or as a result of receipt of a CIR or complaint.
OCDD does not support the use of restraint(which will be referred to as protective supports & procedures)as a true behavioral intervention with application contingent on exhibition of a specific problem behavior on a routine basis. It is only to be used in situations where there is immediate, imminent risk of harm to self or others if physical intervention does not occur. Protective supports & procedures are incorporated in the POC

if use is anticipated based on the participant's behavioral trends & patterns. Behavioral challenges are addressed in an ongoing plan that utilize other appropriate & less restrictive techniques to prevent the problems, de-escalate them when they occur,& teach appropriate options/coping skills/replacement behaviors.
The DSP is responsible for reviewing incidents & trends while OCDD is responsible for reviewing DSP practices & use of protective supports & procedures. Incidents reaching a specified threshold will be reviewed by the OCDD CRC.
Almost any other technique is considered less restrictive than restraint use besides medication for the purposes of sedating the participant or use of aversive conditioning techniques which OCDD does not allow. Plans are written by private psychological service providers & as a result, the techniques will vary, but may include:
Preventive strategy examples:
1.Identification of triggers for the challenging behavior & avoidance of triggers(i.e., noise may be a trigger so efforts are made to avoid loud/crowded spaces);&
2.Identification of things the participant enjoys & times/activities during which the challenging behavior is least likely to occur & providing increased opportunities for accessing meaningful/enjoyable things(i.e., finding someone a job that they enjoy; spending more time with family if this is important, etc.)
Teaching examples:
1.Teaching the participant problem solving, anger management, or relaxation skills to avoid escalation of the challenging behavior & then teaching staff to recognize the early signs of agitation & how to prompt use of the new coping skills; &
2.Reinforcing exhibition of appropriate behavior identified in the plan & not reinforcing the challenging behavior so it is more likely that appropriate behavior alternatives will be chosen.
Intervention examples:
1.Blocking the participant from reaching an object he/she may throw or a person he/she may hit but not actually holding or restraining the participant;&
2.Removing objects that may be used aggressively.
It should be noted that these are only examples in each category of possible strategies. There are many other alternatives that may be used. Each plan is tailored to meet the participant’s needs & is developed by various professionals.
Restraint use requires prior permission. Informed consent is obtained from the participant or his/her legal guardian relevant to the participant’s consent for implementation of the plan. At a minimum, informed consent includes the essential components necessary for understanding the potential risks & benefits of the plan. The participant or legal guardian shall be informed of the right to withhold or withdraw consent at any time. If a restraint is unplanned, as in emergency situations, prior permission is not obtained. Unplanned restraints are based on the fact that the restraint is a response to an emergent situation in which imminent risk of harm exists to person &/or others.
Strategies considered prior to restraint use include Positive Support Procedures (based on the individual support need), Desensitization,assessment by allied health professionals for alternate communication strategies,& identification of possible medical antecedents,etc.
When restraint is used for behavior support procedures,a licensed psychologist authorizes the use. When restraints are used for medical protective supports & procedures(as those applied as a health-related protection)a licensed physician, licensed dentist,or licensed podiatrist,authorizes the use.
The following practices are employed to ensure the health & safety of individuals when restraints are used:
•Staff training and competence: Staff must be competent in the use of restraint methods to avoid/prevent use of restraints & methods for implementing emergency restraints when necessary as a last resort. Required competencies include demonstration of OCDD’s philosophy & policy re:use of restraints & knowledge concerning the conditions necessary for implementation of emergency restraints; competency in use of procedures taught in standard state approved programs for managing aggressive behaviors or an alternate crisis intervention system that does not use prone personal restraints;demonstration of competency in outlined support plan strategies relative to avoiding/preventing use of restraints & any methods for guiding the person more effectively,as well as the use of specific types of emergency restraints before applying them(inclusive of application, release, documentation, monitoring, and other information relative to safety of administering these procedures;staff responsible for visually & continually monitoring the person in behavioral restraints shall demonstrate competency in knowledge/implementation of agency protective support policies, application of protective supports,recognizing signs of distress,recognizing when to contact physician or emergency medical service so as to evaluate/treat the person’s physical status, &

documentation; demonstration of knowledge/competency in,and procedures for accessing emergency medical services rapidly; competency/training in all aspects of applying medical restraints as prescribed by the person's physician (inclusive of training on strategies for reducing time in which medical restraints are required as outlined in support plan and documentation of training on essential steps for applying mechanical restraints and for implementing support plan strategies).
• Implementation: Each agency must have a policy that defines minimum components include defining limitations on use of restraints within the agency in a manner that is consistent with OCDD policy/philosophy on protective supports; a system to identify who is qualified to implement restraints within the agency (with agency maintaining tracking of which staff are trained and when annual re-training is to occur); each agency must have a system for tracking the use of emergency restraints and mechanical restraints, if used; and each agency where emergency restraints are implemented must have safety procedures in place to protect the participant and staff (inclusive of provision of back up staff in the event of an emergency; procedures to check health of the person prior to, during and following implementation of emergent restraints, as well as safety actions to maximize safety of participant/others; procedures for addressing incidents that led to the use of emergency restraints (including development of a Positive Behavior Support Plan that include strategies to prevent/avoid future incidents and is integrated into the support plan); and procures to review incidents within 24 hours so as to prevent, to act quickly, or avoid future incidents).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Providers are required to report measures implemented to mitigate the use of restraints and follow-up in regards to referrals to protective services (if necessary), changes to behavior supports, or staff training.
The provider is responsible for reviewing incidents for trends and patterns within its own agency caseload to determine what quality initiatives may be necessary to provide alternate means of addressing situations which result in restraint at least quarterly.
The support coordination agency is responsible for tracking trends in restraint incidents involving providers who serve participants on the support coordination agency caseload at least quarterly. The support coordinator is responsible for addressing behavioral needs on a quarterly basis and amending the plan of care to ensure positive support strategies are implemented.
LGEs are responsible for quarterly monitoring the reviews conducted by SCAs, to provide technical assistance and assist with referrals for additional services when necessary.
OCDD is responsible for reviewing aggregate data in the critical incident reporting system on the use of protective supports and procedures.
OCDD will present aggregate data to the OCDD Performance Review Committee to determine if any quality initiatives are necessary.
OCDD will provide MPSW with aggregate data and reports which are inclusive of any reported restraint use, remediation strategies and quality improvement initiatives and the results of quality improvement projects on a quarterly basis.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The State prohibits the use of restrictive interventions. The state strategies for detecting unauthorized use of restraints is through review of critical incident reports, complaints, support coordinator quarterly contacts with participants and families and support coordinator unannounced visits.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The State prohibits the use of seclusion. The state strategies for detecting unauthorized use of seclusion is through review of critical incident reports, complaints, support coordinator quarterly contacts with participants and families, and support coordinator unannounced visits.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- (●) **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ( ) **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- ( ) **Not applicable.** *(do not complete the remaining items)*
- ( ) **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
G.a.i.a.1. Number and percentage of substantiated abuse,neglect or exploitation cases where required remediation is completed, as measured by case closure in the incident reporting system. Numerator = Number of substantiated incidents of abuse,neglect or exploitation where required remediation was completed; Denominator = Total number of substantiated allegations.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.a.i.a.2. Number and percentage of deaths requiring a corrective action plan where the corrective action plan was completed as measured by closure of the critical incident in the incident reporting system. Numerator = Number of deaths requiring a corrective action plan where the corrective action plan was completed; Denominator = Total number of deaths requiring corrective action plan.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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:
G.a.i.a.3. Number &percent of abuse, neglect,exploitation,&unexplained death investigations that included evidence of effective resolution & preventative measures. Numerator= Number of investigations that included evidence of effective resolution and preventative measures; Denominator=All investigations completed and transferred to waiver staff.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

	Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
G.a.i.b.1. Number and percentage of critical incidents where all follow-up was completed and proper actions were taken as measured by closure of the critical incident within OCDD's specified timelines . Numerator = Number of critical incidents with completed follow-up and proper action were taken as measured by closure of the critical incident; Denominator = Total number of critical incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Reporting system

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

Data Aggregation and Analysis:

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

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
G.a.i.c.1Number&percent of reported misuse of restraints or seclusion where a prevention plan has been developed as a result of an incident. Number&percent of reported misuse of restraints or seclusion where a prevention plan was developed as a result of an incident/total number of incidents reporting misuse of restraints or seclusion.

Data Source (Select one):
Other
If 'Other' is selected, specify:
incident reporting system

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G.a.i.c.2 Number and percent of reported use of restrictive interventions where a prevention plan has been developed as a result of an incident. Numerator= Number of reported use of restrictive interventions where a prevention plan has been developed as a result of an incident/Denominator= totol number of incidents reporting use of restrictive interventions

Data Source (Select one):
Other
If 'Other' is selected, specify:
incident reporting system

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
G.a.i.d.1 Number and percent of participants who received the coordination and support to access health care services identified in their service plan. Numerator = Number of participants who received the coordination and support to access health care services identified in their service plan; Denominator = Total number of participants reviewed.

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

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

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

ii. Support coordination agencies periodically conduct unannounced visits to participant homes. If a concern is identified during the unannounced visit, then the LGE is notified by the SCA, and the LGE may request a plan of correction from the provider agency.
If a complaint is received by OCDD or the LGEs that has the potential to affect the health and welfare of a participant then the Support Coordinator is notified to conduct an unannounced health and welfare check of all SW participants served by the direct service provider. If additional problems are discovered that affect the health and safety of participants, then a complaint is reported to the Health Standards Section for follow-up.

b. Methods for Remediation/Fixing Individual Problems

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

For Performance Indicators G.a.i.a.1, G.a.i.a.2, G.a.i.b.1, G.a.i.c.1
There are several layers of remediation to address the issues identified in a Critical Incident Report (CIR). They include:

- Primary remediation occurs at the level of the provider agency, where immediate response is required in halting and correcting harmful, dangerous or potentially harmful or dangerous conditions at the time the condition is discovered.
- The support coordinator is responsible for determining any further remediation that can be implemented by way of strategies developed in team meetings with the participant and axillary support services.
- The LGE waiver offices are responsible for reviewing individual critical incidents on a daily basis involving death, attempted suicide, and major illness resulting in hospitalization for pneumonia, bowel obstruction, and uncontrolled seizures and assuring that support coordinators follow through as described in the previous paragraph. The LGE provides technical support to support coordinators as necessary.
- OCDD State Office Quality Section conducts individual reviews of incidents involving waiver participants that meet the threshold for involvement at that level as required in OCDD policy. OCDD State Office generates recommendations to the LGE where each participant resides to further assist in remediation. All critical incidents are tracked for closure by OCDD State Office. If during the OCDD periodic review an LGE fails to close a CIR within the appropriate timelines, then OCDD may request a Corrective Action Plan for improvement.

Performance Indicator G.a.i.a.1

- Remediation of individual cases of substantiated abuse, neglect or exploitation is determined by the appropriate protective services agency (dependent on the waiver participant's age) and/or the DHH Health Standards Section as required in their policies and procedures.

Performance Indicator G.a.i.a.2

- The OCDD conducts individual reviews of all incidents resulting in the death of the waiver participant through the Mortality Review Committee. OCDD may determine the provider and/or support coordinator could improve services, and require a corrective action plan. Follow-up corrective action is also documented in the case file.

Performance Indicator G.a.i.d.1
LGE staff perform monitoring of Support Coordinator Agencies (SCA) at least annually utilizing the OCDD Support Coordination Monitoring Tools: Participant Interview; Participant Record Review; Support Coordinator Interview; and Agency Review. The processes for scoring and determining the necessity for corrective actions are located in the "Updated Guidelines for Scoring, Corrective Action and Follow-up Monitoring." After all elements are assessed and scored, the LGE reviewer documents the findings, including the Statement of Determination which delineates every POC remediation required and required responses/plans of correction expected from the SCA. Based on the scope and severity of findings, the SCA is assigned a Statement of Determination at Level I, Level II, or Level III. The LGE and/or State Office follow-up according to timelines associated with each level to ensure that plans of correction are implemented and effective. Level III determinations are those having the actual or potential for immediate jeopardy. In these cases, the SCA must develop a plan of correction that includes the identification of the problem; full description of the underlying causes of the problem; actions/interventions that target each underlying cause; responsibility, timetable, and resources required to implement interventions; measurable indicators for assessing performance; and plans for monitoring desired progress and reporting results. In addition, OCDD takes enforcement action to assure the health and safety of participants. Actions include, but are not limited to: transfer of participants who are/may be in jeopardy; removal of SCA agency from the freedom of choice list; suspension of all new admissions; financial penalties; suspension of contract/certifications as a provider of SC services.
If a Plan of Correction, Progress Report and/or Follow-up Report remains unapproved by the time of the next annual review the agency placed on the next level with more stringent requirements. With a finding of satisfactory or a recommendation for improvement no remediation is required. These remediation activities will be documented through tracking events in the Support Coordination Monitoring database.
Training will be necessary when trends are detected in plans of care that do not address: participant goals, needs (including health care needs), and preferences; how waiver and other services are coordinated; and identification of responsibilities to implement the plan. The training requirements depend on the Support Coordination Monitoring findings and are based on the criteria found in OCDD Interpretive Guidelines for the OCDD Participant Record Review with a parallel set of guidelines entitled "Guidelines for Support Planning" for support coordinators.
An unsatisfactory plan of care is one with criteria "not met" according to the OCDD Interpretive Guidelines for the OCDD Participant Record Review and parallel set of guidelines entitled "Guidelines for Support Planning" for support coordinators.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The state of Louisiana utilizes a collaborative approach to develop and maintain the Quality Improvement System (QIS). The Medicaid agency in Louisiana, Bureau of Health Services Financing Medicaid Program Support and Waivers (BHSF/MPSW) has oversight for the implementation of Home and Community Based Services (HCBS) Waivers. The Office for Citizens with Developmental Disabilities (OCDD) is the operating agency, and the local operating arm for HCBS Waivers is the Local Governing Entity (LGE). The LGE provides oversight and monitoring of the contracted support coordination agencies; the contracted support coordination agencies provide oversight and monitoring of service utilization. All of the above mentioned entities also work collaboratively with Louisiana protective services agencies, Health Standards Section (HSS) and/or law enforcement as deemed necessary. The process of trending, prioritizing and implementing system improvement activities are required on all levels with upward reporting to the operating agency for oversight and management of the Quality Improvement System including a summary of root cause analysis completed at each level and recommendations for design changes or other system improvements. This approach provides opportunities for continued communication and review of performance measures, discovery and remediation activities.

The Quality Improvement System (QIS) for the Supports Waiver is part of a cross-waiver function of the Office of Aging and Adult Services (OAAS) and the Office for Citizens with Developmental Disabilities (OCDD). The purpose of the QIS is to assess and promote the quality of waiver programs serving older persons and adults with physical, intellectual and developmental disabilities.

The QIS assures a consistent and high standard of quality across waiver programs through:

- Adoption of common standards and performance measures against which waiver programs are evaluated.
- Development of policies, tools, practices, training, protocols, contracts and agreements that embody sound approaches to managing, delivering and assessing HCBS services and supports. To the extent possible, HCBS waiver policies and practices have shared purposes, language and expectations.
- Streamlining and consolidation of functions to strengthen the collection and analysis of timely and reliable data on waiver performance.
- A transparent system of reporting performance data for use by program managers, policymakers, consumers, providers, and other stakeholders.
- A structured and coordinated process to identify improvement opportunities, set priorities, allocate resources, and implement effective strategies.
- A coordinated approach for evaluating the effectiveness of the QIS in meeting program goals.

OCDD has a multi-tiered system for quality improvement. Each level (Direct Service Provider Agency, Support Coordination Agency, Local Governing Entity, OCDD State Office, and BHSF) within the system is required to design and implement a Quality Management Strategy which is further described below.

Direct Service Provider and Support Coordination Agency Processes:

Direct Service Provider and Support Coordination Agencies are required to have a Quality Management Strategy that includes collecting information and data to learn about the quality of services, analyzing and reviewing data to identify trends and patterns, prioritizing improvement goals, implementing the strategies and actions on their quality enhancement plan, and evaluating the effectiveness of the strategies. At a minimum, agencies must review: 1) critical incident data, 2) complaint data, 3) data from case record reviews, and 4) interview/survey data from participants and families. The review process must include review by internal review team(s) composed of agency programmatic and management staff and an external review by the board of directors with stakeholder representation or a separate committee that includes stakeholders. Annually, agencies must submit to OCDD documentation to verify that they engage in ongoing, continuous quality review and enhancement activities.

OCDD LGE Processes:

The LGE is the operating arm for managing the Supports Waiver (SW), and they are also required to have a Quality Management Strategy. This entity represents the primary source for discovery and remediation information regarding the waiver. They are required to collect information on performance indicators, conduct remediation as needed, aggregate data and review to identify trends and patterns and areas in which improvement is needed, and prioritize needed improvements. They are required to design and implement quality enhancement strategies and evaluate the effectiveness of those strategies. Each LGE has a Quality Specialist whose function is to facilitate data analysis and review. Within each LGE, data review is conducted by programmatic and management staff and by the Regional Advisory Committee which is composed of stakeholders. OCDD State Office staff visit each LGE annually to validate the quarterly/annual data reported to State Office on performance indicators, to assure that remediation and system improvements occur as needed, and to provide technical assistance. When performance falls below the outlined measure, the LGE submits evidence to the operating agency, OCDD, with documentation of the quality improvement activities that have been implemented to improve performance. If the performance is not improved as outlined in the established benchmark, technical assistance will be provided to the LGE.

OCDD State Office Processes:
Aggregate data for waiver performance indicators are reviewed for trends and patterns on a quarterly or annual basis by the OCDD Waiver Section (program personnel) and Quality Section. These groups review data to ensure remediation is being completed by the LGE and to analyze the data for systemic concerns across waivers and across LGEs. Upon completion of the analysis, a representative from these teams presents data to the OCDD Performance Review Committee, with recommendations for system improvement. The OCDD Performance Review Committee is composed of designated members from each of the OCDD sections: Quality, Business Analytics, Clinical, Waiver, Early Intervention, and other members as designated by the OCDD Executive Management Staff. This provides the committee with expertise from several disciplines when reviewing recommendations. It also affords OCDD the opportunity to utilize existing expertise, processes, and tools to address new concerns, recommend strategies, and recommend systemic improvement that is best practice to ensure quality improvement and success. These recommendations are presented to OCDD Executive Management for consideration and approval. When significant system changes are proposed, the OCDD Core Stakeholder Group is convened and given the opportunity to review the proposed systemic changes and provide input regarding the recommendations. . The Core Stakeholder Group is comprised of waiver participants, families of waiver participants, advocacy groups, including the state DD Council, and a representative from the Governor's office, and meets as needed based on system improvement activities. Recommendations, performance indicator data reports, and quality improvement initiatives status reports are also submitted to the Bureau of Health Services Financing (BHSF) on a quarterly basis.
BHSF/MPSW Processes:
Medicaid/Program Offices Quarterly Meeting – This group convenes at least quarterly to perform executive level oversight of the performance of HCBS waivers, assure their effectiveness and efficiency, and discuss any other programmatic issues common to the program offices and Medicaid. Goals are to act upon issues and recommendations received from the Medicaid HCBS Oversight Committee and other HCBS workgroups. This meeting is a forum for executive level problem resolution, planning, and development of quality redesign strategies. Members include representatives from MPSW, the Medicaid Director or Deputy Director, the OCDD Assistant Secretary or Deputy Assistant Secretary, and other designated staff.
Medicaid HCBS Oversight Committee – meets at least quarterly with the specific purpose to ensure proper oversight of the OAAS and OCDD operated HCBS Medicaid programs. Goals are to review current performance reports, determine need for new activities concerning quality and oversight in waiver programs, and ensure adequate remediation enforcement. Quality recommendations or issues which cannot be resolved at this level are placed on the agenda of the Medicaid/Program Offices Quarterly Meeting. Oversight members include HCBS quality management staff from MPSW and OCDD and are chaired by the MPSW Section Chief or designee. The committee meets at least quarterly with the following standing agenda items:
-OCDD operating agency staff present their analysis of all performance measure findings, remediation activities, and systemic improvements to MPSW as defined in the 1915© waiver quality strategy

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: Medicaid HCBS Oversight Committee	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

OCDD Process:
Following system design changes, data on performance indicators are reviewed by the Waiver and Quality program staff, as well as the OCDD Performance Review Committee to assure that the information is useful and accurate and to determine if performance has improved. Input is sought, as appropriate, from Support Coordination and Direct Service Provider Agencies, participants and their families, and other stakeholders, to determine whether the system design change is helping to improve efficiency and effectiveness of waiver supports and services. At this point, the Core Stakeholder Group may be convened, if needed, to address if system improvement has resulted from the system design/improvement activities.
BHSF/MPSW Processes:
Medicaid HCBS Oversight Committee – meets at least quarterly with the specific purpose to ensure proper oversight of the OAAS and OCDD operated HCBS Medicaid programs. Goals are to review current performance reports, determine need for new activities concerning quality and oversight in waiver programs, and ensure adequate remediation enforcement. Quality recommendations or issues which cannot be resolved at this level are placed on the agenda of the Medicaid/Program Offices Quarterly Meeting. Oversight members include HCBS quality management staff from MPSW and OCDD and the committee is chaired by the MPSW Section Chief or designee. The committee meets at least quarterly with the following standing agenda items:
-OCDD operating agency staff present their analysis of all performance measure findings, remediation activities, and systemic improvements to MPSW as defined in the 1915© waiver quality strategy
-MPSW Section Chief or designee indicates approval or disapproval of quarterly/annual data and activities;
-Based on evidence presented, MPSW staff provides technical assistance, guidance, and support to the operating agency staff;
-MPSW performs administrative oversight functions for OCDD HCBS program.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Medicaid Program Support and Waivers Section works in collaboration with the operating agency, OCDD, to periodically review the quality improvement strategies. Meetings are held to review and evaluate the performance indicators, discovery methods, remediation strategies, systemic issues, policies, procedures and any other issues that have surfaced as a result monitoring activities. Technical assistance is provided to the operating agency as needed by Bureau of Health Services Financing Medicaid Program Support and Waivers (BHSF/MPSW).
The operating agency, OCDD, has a Performance Review Committee which meets at least quarterly and provides ongoing oversight and management of the Quality Improvement System.
OCDD participates in the annual National Core Indicator (NCI) surveys which are addressed to a random sample of participants and families of participants to gauge their satisfaction with OCDD waiver services, and with the performance of support coordinators, LGEs and providers. OCDD aggregates findings to identify areas of concern in service delivery in order to initiate quality improvement strategies.
Findings from this annual review will be analyzed by the Performance Review Committee to revise the QIS. Modifications may be made to quality standards and measures, data collection tools and methods, report formats documenting performance, or dissemination strategies for sharing performance data. New priority projects may be identified to better align the QIS to the needs of waiver managers, LGE program staff, support coordinators and providers and, most significantly, to improve desired outcomes for HCBS waiver participants. The modifications and priorities identified by the Performance Review Committee will be implemented or facilitated by the OCDD Quality Enhancement Section.
Findings from this annual review will be analyzed by the Performance Review Committee to revise the QIS. Modifications may be made to quality standards and measures, data collection tools and methods, report formats documenting performance, or dissemination strategies for sharing performance data. New priority projects may be identified to better align the QIS to the needs of waiver managers, LGE program staff, support coordinators and providers and, most significantly, to improve desired outcomes for HCBS waiver participants. The modifications and priorities identified by the Performance Review Committee will be implemented or facilitated by the OCDD Quality Enhancement Section.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ◉ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

All Medicaid providers will be required to fulfill the requirements under the provision of the Single Audit Act to maintain Medicaid enrollment. The Louisiana Legislative Auditor (LLA) is the entity that is responsible for conducting the periodic independent audit of the waiver program under the provisions of the Single Audit Act. Medicaid staff will ensure that any provider receiving the amount of funds specified in the Single Audit Act will be required to provide a copy of the independent audit for continued Medicaid enrollment on an annual basis. Disenrollment will occur as a result of non-compliance. Program Integrity's Surveillance and Utilization Review (SUR) Unit is responsible for conducting post-payment reviews of all fee-for-service Medicaid providers. The post-payment review process used by the Program Integrity Section within the Louisiana Department of Health (LDH) is described in the Louisiana Surveillance and Utilization Review Subsystem (SURS) Rule and the Medical Assistance Program Integrity Law (MAPIL). The SURS Rule is available online through the Louisiana Register at the following website address: http://www.doa.la.gov/osr/reg/1211/1211.pdf (Pages 97-111 of the pdf or 2774-2788 of the hardcopy). Specifically the rule may be found through the following citation: Louisiana Administrative Code 50:I.Chapter 41.

Waiver providers are selected and profiled. The providers that meet the exception criteria in the Surge run are screened/reviewed. Cases on Waiver providers are derived from multiple sources such as ad hoc data mining, the Surge by Region run, the HCPCs Outlier run, projects (such as services billed while the recipient is in the hospital) and complaints. Complaints are received via mail, fax, website and hotline. Sources for cases come from complaints, referrals (internal and external) and data mining (regularly scheduled data runs and ad hoc data runs). A team made up senior analysts and a supervisor triages all complaints. Onsite visits are determined on a case by case basis and depends on the severity of the complaint. The primary means of receiving documentation needed for the review is via mail, fax or electronic. Reasons for on-site vary. If a provider does not make available documentation requested for a review, the SURS analyst may be instructed to perform an on-site. If multiple complaints are received on the same provider, an on-site may be the method of retrieving documentation. A random sample of recipients is selected or a specific recipient may be addressed depending on the details of the complaint or reason(s) for the case opening. Sample selection uses a univariant sampling technique which allows all recipients equal chance of being selected. There is no weighting of recipients due to number of claims, amount paid, or any other factor. Generally, a scientific sample of 20 recipients is used. The basic logic for the scientific sampling process is:
1) A universe of claims/encounters is defined and the claims/encounters meeting the selection criteria are extracted.
a. Some criteria can be Provider ID, Procedure Codes, Medicare coverage, or other identifying claim/encounter characteristic.
2) The universe is read and each of the unique recipient ids are extracted.
3) Each unique recipient id is assigned a "uniform" random number using the SAS built-in UNIFORM () function. This is to ensure that each recipient will have an equal chance of being selected.
4) The recipients are sorted using the random number, as to create a random listing of the recipient ids.
5) The recipients with the lowest random numbers assigned to them are selected until the requested sample size is reached.
6) The claim/encounter records associated with the selected recipient ids are extracted for reporting and analysis.

All documentation to support the services billed are requested: timesheets, daily logs, etc. Additional information is also requested for the direct service worker which includes employee records and any other associated documentation from the provider agency. Complete copies of the personnel files of all employees employed during the time period reviewed who provided care for the recipients on the attached page. List names, title, education levels, and job descriptions. Include copies of applications, driver's licenses, current addresses, results of criminal background checks, and all certifications and/or trainings.

The SURS data mining team produces computer runs that generate open cases. Providers whose income spikes from one period to another are identified through exception processing and will generate case openings.
Post-payment reviews are triggered when potential fraud, waste and abuse is identified either through a complaint, referral or data mining. SURS opens complaint cases throughout the year after the triage process. Some data mining runs (such as SURGE or Spike runs, date of death runs, outlier runs, etc.) are done on a fixed schedule. Other data mining runs are done on an ad hoc basis where project cases are opened and are usually policy-focused. For example, providers billing for in-home services while the recipients are hospitalized.

SURGE Run is a computer run that is produced on a regular basis that identifies providers that meet a set of criteria and/or conditions. The run looks for providers with incomes that surge.
Enrolled providers are divided by regions established by the Louisiana Department of Health (LDH). The computer runs are done by region. There are a total of 10 computer runs. There are 9 in-state runs and 1 out-of-state run. Runs are done on a monthly basis with the exception of the month of June and December. Providers are selected based on 3 criteria: location, amount paid and percent change in amount paid.
•First, a provider must be located in the region that is being reviewed.

•Secondly, a provider must have generated a minimum dollar amount paid in a 12 month period to be included for processing.
•And finally, a provider must have had a "surge" in income from a six month period in one year to a six month period in another year.

SURGE by Region (SBR) Run is a production run that is used to monitor the activity of providers enrolled in the Louisiana Medicaid Program. The run identifies providers with a significant increase or "spike" in the billing. The basic concept of the SBR run is to compare a provider's income for six months in one year to his or her income for six months in the following year. This run is a valuable tool because any significant increase in a provider's income is detected and a review of the provider's billing pattern is done to determine the reasons for the change. Enrolled providers are divided by regions established by the Louisiana Department of Health (LDH). The computer runs are done by region. There are a total of 10 computer runs. There are 9 in-state runs and 1 out-of-state run. Runs are done on a monthly basis with the exception of the month of June and December. Providers are selected based on 3 criteria: location, amount paid and percent change in amount paid. First, a provider must be located in the region that is being reviewed. Secondly, a provider must have generated a minimum dollar amount paid in a 12 month period to be included for processing. And finally, a provider must have had a "surge" in income from a six month period in one year to a six month period in another year. The provider types are divided into 3 groups based on an income threshold: Group A = $75,000, Group B = $150,000 and Group C = $300,000. Providers in each group have to meet or exceed the minimum income threshold. Cases are opened using the following process. A SBR run is submitted in J-SURS according to the run schedule. The run generates a list of providers who meet the criteria or who except. A basic screening is performed on each of the providers on the exception list to determine if a case will be opened. Cases that pass the screening are opened and tracked as a "SURGE" case type in the SURS database. When a SURGE case is opened, two reports are available to assist with the case analysis: an individualized exception profile on the provider and a report with peer group data. An exception profile on the provider gives information specific to the individual servicing provider such as dollar and claim averages per recipients, recipients by age and gender, reimbursements by dollar categories, percent changes, etc. for six months in one year as well as metrics for six months in the following year. Top procedure codes paid and top diagnoses billed for the individual servicing provider are displayed for each six month period. A peer group comparison run is done on the provider type and specialty that includes a provider ranking by amount paid, top procedure codes paid, and top diagnoses billed. The reports deliver a comparison of the provider from one period to another period as well as a comparison of the provider to his or her peer group.

Ad hoc data runs are designed to look at more specific issues like waiver services billed while the recipient is in the hospital or dates of service after a recipient's date of death or direct service workers employed who are excluded from participating in the Medicaid program.

A variety of professional staff are used to perform fraud, waste and abuse reviews. Analysts conducting the reviews are primarily Registered Nurses; however, there are dental hygienists and social workers on staff. In addition to the analysts, professional consultants are utilized such as physicians with different specialties, dentists, etc. Complaints are sent to the triage team, which is made up of professional staff that screen complaints for fraud, waste and abuse. If fraud, waste and abuse is involved, further research is done to determine if a comprehensive or focused review is done. Referrals are also made to professional licensing boards, local law enforcement, the Medicaid Fraud Control Unit (MFCU), child/adult protection, DHH program managers, etc. All SURS cases are worked by a professional staff analyst.
Once the review is completed by the analyst, the Quality Assurance (QA) team reviews the findings closely. Also, during the review process, medical consultants may give input as well as the Program Integrity Director and LDH program managers. After the case has completed the QA process, the findings of the review are also reviewed by the RN Supervisors. From there, the correspondence to provider detailing the results of the audit is presented by the RN Supervisors to the Program Integrity Director and manager. After the findings letter is sent, the provider is entitled to an informal hearing as well as an appeal hearing and judicial review. Once the review findings have been confirmed and finalized, any overpayments due are collected. The provider receives a recoupment letter with the specific areas of review. The provider has an opportunity to submit additional information, request an informal hearing with LDH or request an appeal. The provider can pay the overpayment amount in full or request a payment plan. In addition to recovering overpayments, SURS may request a corrective action plan to remedy the billing or programmatic issue identified.
Continued in Optional Section

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States

methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
I.a.i.a.1. # and % of waiver claims coded & paid for in accordance with the reimbursement methodology specified in the approved waiver application and only for those services rendered. Numerator=# of waiver claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver application and only for those services rendered;Denominator= Total # of claims paid.

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

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

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

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

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

Performance Measure:
I.a.i.b.1. Number and percentage of rate changes that are approved by MPSW and consistent with the CMS approved rate methodology. Numerator= Number of rate changes approved by MSPW and consistent with the CMS approved rate methodology; Denominator= Total number of rate changes.

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

I.a.i.a.1. BHSF determines all waiver payment amounts/rates in collaboration with OCDD, Division of Health Economics, and as necessary the Rate & Audit section. At the time of each requested rate change, MPSW and the Rate and Audit section reviews evidence that the rate adjustment was applied according to the methodology described in the waiver document. When a rate adjustment proposal is submitted without documentation which supports the current methodology it will not be approved and MPSW will offer technical guidance.
I.a.i.b.1 Upon annual review and analysis of all waiver claims payments through Medicaid Data Warehouse report generation, any discrepancies are resolved individually and systemically in collaboration with Medicaid Information Management Systems staff who oversee the Fiscal Intermediary.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The Office of Citizens with Developmental Disabilities (OCDD) determines the rates of payment for services. Service rates are promulgated by Medicaid through a rulemaking process, which includes opportunity for public input through written comments, which are entered into record, and a public hearing, where comments may be read into record. This process affords Medicaid oversight of the rate determination process.

The rates in the Supports Waiver were established when the waiver was created back in 2006. With the exception for a couple of changes to the rate due to appropriation changes or changes in unit of service, the rates have basically remained the same.

The Rate Subcommittee used three years of data from state vocational services to create the Supports Waiver service rates before the inception of the waiver. The Rate Subcommittee was disbanded after the waiver application was submitted and approved in 2006.

Rates for Supported Employment, Day Habilitation, and Prevocational were based on ten years of historic usage of these services, and costs of providing these services as evidenced by data from a 3-year pilot project in which nine small, medium and large, urban and rural state general funded contracted Vocational and Habilitation Providers participated. The project broke down line item costs for each approved cost category, as well as showing specific individual's outlier costs each month. Information from the project was shared with all current state general funded Vocational and Habilitation providers, and other stakeholders. The Rates Subcommittee used this information to develop the specific rates for these three services. The cost of Prevocational Services is based upon the provider cost of rendering the service and then adjusted based on the availability of state funding or LDH's ability to secure appropriation. Transportation rate is part of onsite day habilitation, Community Life Engagement services, onsite prevocational services, and community career planning. However, for Virtual Day Habilitation and Virtual Prevocational Services, there is not a transportation cost included as it is not required.

The Rates Subcommittee set Respite and Habilitation rates at the current rate being paid through the New Opportunities Waiver (NOW) for Individual and Family Support (which includes Respite and Personal Care Attendant services). Family members requested that the compensation for these two services remain at the current NOW rate in order to attract quality staff. The NOW waiver rates were defined by actual service costs, reviewed and approved by the NOW stakeholder group. The cost of In-home Respite is based upon the provider cost of rendering the service and then adjusted based on the availability of state funding or LDH's ability to secure appropriation.

The cost of Personal Emergency Response System is based on actual utilization costs from 239 providers of the service over a 12-month period.

Support Coordination was one of the services addressed by the Rate Subcommittee. The original rate was based on the State Plan Support Coordination services provided for recipients in the New Opportunities Waiver who would represent a similar population to be served. Several adjustments were made based on assumptions of the workload and vocational planning. As with all other SW services, the rate has remained constant with the exceptions being changes in appropriation.The cost of Support Coordination services are based upon the provider cost of rendering the service and then adjusted based on the availability of state funding or LDH's ability to secure appropriation.

The cost of Prevocational Services is based upon the provider cost of rendering the service and then adjusted based on the availability of state funding or LDH's ability to secure appropriation. The cost of In-home Respite is based upon the provider cost of rendering the service and then adjusted based on the availability of state funding or LDH's ability to secure appropriation.

Both Housing Stabilization and Housing Stabilization Transition Service rates are based on the rate paid to support coordination agencies, which employ individuals who have obtained a bachelor's degree and are qualified to provide two levels of supervision. An agency trainer or nurse consultant who meets the requirements as a support coordinator can also be reimbursed a per quarter hour rate for services provided. Administrative support, travel and office operating expenses are included in the 15 minute billing rate.

The Rates for Specialized medical equipment and supplies were developed from existing Medicaid rates for similar or same services.

Please refer to LA.0005, Section D and accompanying Cost Effectiveness workbook for rate determination methods. Dental services are capitated and rates are submitted to CMS for approval as part of the Dental Benefit Plan Manger (PAHP) rate certification and contract amendment process.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Billings for waiver services provided to participants in the waiver program are submitted first to the data contractor for post authorization. After services are authorized, providers bill directly to the Medicaid fiscal intermediary for payment.

Billings for dental services are submitted directly by provider(s) to the Dental Benefit Plan/PAHP. The plan is required per contract to submit encounters to the State's MMIS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

OCDD will use a prior authorization and post authorization system to insure that services provided and paid for are in accordance with the Plan of Care (POC).
Medicaid eligibility for services is checked and reviewed by the prior authorization entity. The Supports Waiver uses a system of prior and post authorization to ensure that services provided to waiver participants are provided in the scope, duration, and frequency as outlined in the participants plan of care. Services are prior authorized by the POC in quarterly increments and post authorized for payment after services have been rendered. DHH currently uses a contracted entity for its prior and post-authorizations.
All Medicaid waiver services are paid through prior authorization. Before any payments are made for Medicaid services, the participant is checked for eligibility for waiver services by the state fiscal intermediary. If the date of service matches Medicaid and waiver eligibility, then the claim is paid. If not, the claim is denied and a denial code of service ineligibility is given for the claim.
1. POC prescribed services are entered in the prior authorization system quarterly.
2. Upon the provision of services to the SW participant, the provider submits data on the services provided to our post authorization entity which checks the service record against the POC listed and prior authorized services.
3. Services properly rendered to participants as prescribed by the POC are then eligible for payment and the post authorization for payments is released to the fiscal intermediary.
4. The provider then submits claims for approved services to the fiscal intermediary for adjudication and payment.
5. Services provided to the participant not listed on the prior authorization system are rejected and ineligible for payment until all discrepancies are resolved.
Additionally, through Program Integrity's Surveillance and Utilization Review (SUR) process, providers are reviewed to ensure that services are actually provided for claims that are paid. In addition, it is the responsibility of the providers to ensure that the services are provided in accordance with the approved plan of care, maintain adequate supporting documentation of services provided and to complete data entry into the data contractor's database that captures services provided and releases authorization for payment.

Regarding dental services, each dental plan receives a monthly file from the SMA indicating which individuals are eligible to receive services and what services they may receive. Adult waiver participants enrolled with a dental plan are identified with a linkage type indicating their covered services.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ◉ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

  Dental services are the only waiver service not paid directly through the state MMIS. Dental providers will receive payment through their contracted PAHP and will not receive payments directly from the Medicaid agency. Each PAHP contracts with providers to deliver dental services utilizing a risk-based payment methodology. PAHPs are required to submit encounter data for each claim to the state's MMIS.

- ○ ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds

expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

State Developmental Centers, which are public ICF/DDs currently provide Supported Employment, Day Habilitation, and Prevocational Rehabilitation to waiver participants. A State Developmental Center may provide any of the services in the Supports Waiver as long as they obtain the appropriate license, and enroll as a waiver provider of the specific service(s).

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ◉ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- ☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***
- ☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

◉ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

○ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***

○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) **No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	6583.40	9455.00	16038.40	78644.00	4521.00	83165.00	67126.60
2	6776.89	9597.00	16373.89	79430.00	4589.00	84019.00	67645.11
3	6968.38	9741.00	16709.38	80225.00	4658.00	84883.00	68173.62
4	7435.65	9887.00	17322.65	81027.00	4728.00	85755.00	68432.35
5	8504.08	10035.00	18539.08	81837.00	4798.00	86635.00	68095.92

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	2100	2100
Year 2	2300	2300
Year 3	2400	2400

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 4	2900	2900
Year 5	3000	3000

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The Average Length of Stay was updated based on the CMS 372 2017-2018 Lag Report. We also included newly run data based on the date of service logic as used in the 372 report from the Medicaid MARS data warehouse. This was included because we found a service count error on the 372 on the service side.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

The CMS 372 Report for 2017 – 2018 was used for the initial Factor D estimate. From that point, the state made estimates on program utilization based on the following factors:

The state has moved to an "Employment First" state. Due to this, the state expects to see an increase in Supported Employment services with an expected decrease in Prevocational services. Additionally, Prevocational Services are now time limited with an expected outcome of competitive employment. In addition to the increase in Supported Employment service utilization, we expect an increase in Day Habilitation services for those who do not work due to the time limitation of prevocational services.

Additionally, the State of Louisiana recently implemented a "most appropriate waiver" system of offering waiver opportunities. To eliminate the list of persons waiting for services, the State made offers to individuals on the waiting list who met the urgent or emergent urgency of need criteria. The increase in unduplicated recipients is projected based on possible offers to adults who meet the urgent and emergent category. The Supports Waiver will be offered first to individuals who are made a waiver offer. These increases reflect what we think will be the number of persons coming into the waiver.

When the 372 Reports a zero for a service, in an abundance of caution, that State always puts a minimum number of participants and services in Section J calculations just in case utilization of the service occurs which is always a possibility. We think it is unwise to use zeroes in the calculation and would rather over-estimate the unduplicated recipients and cost than to underestimate.

We updated the Average Length of Stay based on the provided lag report. We also included newly run data based on date of service logic as used in the 372 Report from the Medicaid MARS Data Warehouse. This included because we found a service count error on the 372 on the service side.

Dental services were added effective 7/1/22 (WY 4). Rates are based on an estimated monthly capitation payment and assume a 3% growth rate annually. The number of users represents the total projected number of adult participants for the waiver year and factors in the average length of stay for the waiver. A monthly capitation payment will be paid for every adult each month they are enrolled in the waiver. Children under the age of 21 years are excluded from this estimate as they already receive comprehensive dental benefits through the State Plan EPSDT benefit.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The CMS 372 Report for 2017 – 2018 was used for Factor D' estimates.

Factor D' is an estimate based on the actual participant expenditures for all other Medicaid services outside of waiver services. This dollar amount is totaled and then divided by the number of waiver participants to get an estimated average cost. A utilization inflation factor is thereby applied to each subsequent year based on state general funded vocational and habilitation program history and other factors. Medicare Part D recipients who participate in this waiver will be identified through their designated eligibility criteria. All related pharmacy expenditures related to these recipients will be deducted from the total acute Medicaid expenditures before the calculation of the average cost.

The 1.5% increase factor for G' and D' is based on using one half of the 5 year average increase for acute FFS costs. We have averaged approximately 2.98% increase in cost for acute FFS, so we elected to take one half of that rate for the D' and G' projections.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The CMS 372 Report for 2017 – 2018 was used for Factor G estimates.

Factor G is an estimate based on the actual Medicaid expenditures for all intermediate care facilities for the developmentally disabled(ICF/DD). This dollar amount is totaled and then divided by the number of waiver recipients to get an estimated average cost. The 1% increase factor is based on the previous 5 year growth rate. The growth rate has been below 1%, however, in order to not underestimate the growth, we selected a 1% increase factor.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The CMS 372 Report for 2017 – 2018 was used for Factor G' estimates. The 1.5% increase factor for G' and D' is based on ½ of the 5 year average for acute FFS costs. We have average approximately 2.98% increase in cost for acute FFS, so we elected to take half of that rate for the D' and G' projections.

Factor G' is an estimate based on the actual Medicaid expenditures for all other Medicaid services provided to citizens residing in intermediate care facilities for the developmentally disabled(ICF/DD). This dollar amount is totaled and then divided by the number of waiver recipients to get an estimated average cost. A utilization inflation factor is thereby applied to each subsequent year based on program history and other factors. Medicare Part D recipients who are served in ICF/DDs will be identified through their designated eligibility criteria. All related pharmacy expenditures related to these recipients will be deducted from the total acute Medicaid expenditures before the calculation of the average cost.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Day Habilitation	
Habilitation	
Prevocational Services	
Respite	
Support Coordination	
Supported Employment	
Specialized Medical Equipment and Supplies	
Dental Services	
Housing Stabilization Service	
Housing Stabilization Transition Service	
Personal Emergency Response System	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:							**4270531.44**
Day Habilitation	☐	15 minute	644	2798.00	2.37	**4270531.44**	
Habilitation Total:							**615400.00**
Habilitation	☐	15 minute	500	340.00	3.62	**615400.00**	
Prevocational Services Total:							**1171033.35**
Prevocational Services	☐	15 minute	257	2463.00	1.85	**1171033.35**	
Respite Total:							**13541.50**
Respite	☐	15 minute	14	265.00	3.65	**13541.50**	
Support Coordination Total:							**3517588.80**
Support Coordination	☐	monthly	2095	11.00	152.64	**3517588.80**	
Supported Employment Total:							**4203799.40**
Supported Employment	☐	15 minute	551	185.00	41.24	**4203799.40**	
Specialized Medical Equipment and Supplies Total:							**0.00**
Specialized Medical Equipment and Supplies	☐	per item	0	0.00	0.96	**0.00**	
Dental Services Total:							**0.00**
Dental Services	☒	monthly	0	0.00	125.00	**0.00**	
Housing Stabilization Service Total:							**1390.12**
Housing Stabilization Service	☐	15 minutes	23	4.00	15.11	**1390.12**	

GRAND TOTAL:	**13825137.03**
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	13825137.03
Total Estimated Unduplicated Participants:	**2100**
Factor D (Divide total by number of participants):	**6583.40**
Services included in capitation:	0.00
Services not included in capitation:	6583.40
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Housing Stabilization Transition Service Total:							**1390.12**
Housing Stabilization Transition Service	☐	15 minutes	23	4.00	15.11	**1390.12**	
Personal Emergency Response System Total:							**30462.30**
Personal Emergency Response System	☐	monthly	102	11.00	27.15	**30462.30**	

GRAND TOTAL:	**13825137.03**
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	13825137.03
Total Estimated Unduplicated Participants:	**2100**
Factor D (Divide total by number of participants):	**6583.40**
Services included in capitation:	0.00
Services not included in capitation:	6583.40
Average Length of Stay on the Waiver:	339

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:							**4908957.30**
Day Habilitation	☐	15 minute	705	2938.00	2.37	**4908957.30**	
Habilitation Total:							**673247.60**
Habilitation	☐					**673247.60**	

GRAND TOTAL:	**15586846.78**
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	15586846.78
Total Estimated Unduplicated Participants:	**2300**
Factor D (Divide total by number of participants):	**6776.89**
Services included in capitation:	0.00
Services not included in capitation:	6776.89
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		15 minute	547	340.00	3.62		
Prevocational Services Total:							**1277848.65**
Prevocational Services	☐	15 minute	267	2587.00	1.85	**1277848.65**	
Respite Total:							**14508.75**
Respite	☐	15 minute	15	265.00	3.65	**14508.75**	
Support Coordination Total:							**3851717.76**
Support Coordination	☐	monthly	2294	11.00	152.64	**3851717.76**	
Supported Employment Total:							**4824337.68**
Supported Employment	☐	15 minute	603	194.00	41.24	**4824337.68**	
Specialized Medical Equipment and Supplies Total:							**0.00**
Specialized Medical Equipment and Supplies	☐	per item	0	0.00	0.96	**0.00**	
Dental Services Total:							**0.00**
Dental Services	☒	monthly	0	0.00	125.00	**0.00**	
Housing Stabilization Service Total:							**1390.12**
Housing Stabilization Service	☐	15 minutes	23	4.00	15.11	**1390.12**	
Housing Stabilization Transition Service Total:							**1390.12**
Housing Stabilization Transition Service	☐	15 minutes	23	4.00	15.11	**1390.12**	

GRAND TOTAL:	**15586846.78**
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	15586846.78
Total Estimated Unduplicated Participants:	**2300**
Factor D (Divide total by number of participants):	**6776.89**
Services included in capitation:	0.00
Services not included in capitation:	6776.89
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System Total:							**33448.80**
Personal Emergency Response System	☐	monthly	112	11.00	27.15	**33448.80**	

GRAND TOTAL:	**15586846.78**
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	15586846.78
Total Estimated Unduplicated Participants:	**2300**
Factor D (Divide total by number of participants):	**6776.89**
Services included in capitation:	0.00
Services not included in capitation:	6776.89
Average Length of Stay on the Waiver:	339

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:							**5381227.20**
Day Habilitation	☐	15 minute	736	3085.00	2.37	**5381227.20**	
Habilitation Total:							**702786.80**
Habilitation	☐	15 minute	571	340.00	3.62	**702786.80**	
Prevocational Services Total:							**1275700.80**
Prevocational Services	☐	15 minute	264	2612.00	1.85	**1275700.80**	
Respite Total:							**15476.00**

GRAND TOTAL:	**16724108.92**
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	16724108.92
Total Estimated Unduplicated Participants:	**2400**
Factor D (Divide total by number of participants):	**6968.38**
Services included in capitation:	0.00
Services not included in capitation:	6968.38
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite	☐	15 minute	16	265.00	3.65	15476.00	
Support Coordination Total:							4019621.76
Support Coordination	☐	monthly	2394	11.00	152.64	4019621.76	
Supported Employment Total:							5291751.84
Supported Employment	☐	15 minute	629	204.00	41.24	5291751.84	
Specialized Medical Equipment and Supplies Total:							0.00
Specialized Medical Equipment and Supplies	☐	per item	0	0.00	0.96	0.00	
Dental Services Total:							0.00
Dental Services	☒	monthly	0	0.00	125.00	0.00	
Housing Stabilization Service Total:							1450.56
Housing Stabilization Service	☐	15 minutes	24	4.00	15.11	1450.56	
Housing Stabilization Transition Service Total:							1450.56
Housing Stabilization Transition Service	☐	15 minutes	24	4.00	15.11	1450.56	
Personal Emergency Response System Total:							34643.40
Personal Emergency Response System	☐	monthly	116	11.00	27.15	34643.40	

GRAND TOTAL:	16724108.92
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	16724108.92
Total Estimated Unduplicated Participants:	2400
Factor D (Divide total by number of participants):	6968.38
Services included in capitation:	0.00
Services not included in capitation:	6968.38
Average Length of Stay on the Waiver:	339

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:							**5605263.30**
Day Habilitation	☐	15 minute	805	2938.00	2.37	**5605263.30**	
Habilitation Total:							**732326.00**
Habilitation	☐	15 minute	595	340.00	3.62	**732326.00**	
Prevocational Services Total:							**1284057.25**
Prevocational Services	☐	15 minute	245	2833.00	1.85	**1284057.25**	
Respite Total:							**16443.25**
Respite	☐	15 minute	17	265.00	3.65	**16443.25**	
Support Coordination Total:							**4187525.76**
Support Coordination	☐	monthly	2494	11.00	152.64	**4187525.76**	
Supported Employment Total:							**6249344.64**
Supported Employment	☐	15 minute	656	231.00	41.24	**6249344.64**	
Specialized Medical Equipment and Supplies Total:							**0.00**
Specialized Medical	☐	per item	0	0.00	0.96	**0.00**	

GRAND TOTAL:	***21563393.85***
Total: Services included in capitation:	*3449275.00*
Total: Services not included in capitation:	*18114118.85*
Total Estimated Unduplicated Participants:	***2900***
Factor D (Divide total by number of participants):	***7435.65***
Services included in capitation:	*1189.00*
Services not included in capitation:	*6246.25*
Average Length of Stay on the Waiver:	*339*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Equipment and Supplies							
Dental Services Total:							**3449275.00**
Dental Services	☒	monthly	2455	11.24	125.00	**3449275.00**	
Housing Stabilization Service Total:							**1511.00**
Housing Stabilization Service	☐	15 minutes	25	4.00	15.11	**1511.00**	
Housing Stabilization Transition Service Total:							**1511.00**
Housing Stabilization Transition Service	☐	15 minutes	25	4.00	15.11	**1511.00**	
Personal Emergency Response System Total:							**36136.65**
Personal Emergency Response System	☐	monthly	121	11.00	27.15	**36136.65**	

GRAND TOTAL:	**21563393.85**
Total: Services included in capitation:	3449275.00
Total: Services not included in capitation:	18114118.85
Total Estimated Unduplicated Participants:	**2900**
Factor D (Divide total by number of participants):	**7435.65**
Services included in capitation:	1189.00
Services not included in capitation:	6246.25
Average Length of Stay on the Waiver:	339

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:							**6663648.42**
Day Habilitation	☐	15 minute	957	2938.00	2.37	**6663648.42**	
Habilitation Total:							**761865.20**
Habilitation	☐	15 minute	619	340.00	3.62	**761865.20**	
Prevocational Services Total:							**1219497.80**
Prevocational Services	☐	15 minute	223	2956.00	1.85	**1219497.80**	
Respite Total:							**16443.25**
Respite	☐	15 minute	17	265.00	3.65	**16443.25**	
Support Coordination Total:							**4353750.72**
Support Coordination	☐	monthly	2593	11.00	152.64	**4353750.72**	
Supported Employment Total:							**7031420.00**
Supported Employment	☐	15 minute	682	250.00	41.24	**7031420.00**	
Specialized Medical Equipment and Supplies Total:							**1730275.20**
Specialized Medical Equipment and Supplies	☐	per item	823	2190.00	0.96	**1730275.20**	
Dental Services Total:							**3694573.95**
Dental Services	☒	monthly	2553	11.24	128.75	**3694573.95**	
Housing Stabilization Service Total:							**1571.44**
Housing Stabilization Service	☐	15 minutes	26	4.00	15.11	**1571.44**	

GRAND TOTAL:	**25512247.32**
Total: Services included in capitation:	3694573.95
Total: Services not included in capitation:	21817673.37
Total Estimated Unduplicated Participants:	**3000**
Factor D (Divide total by number of participants):	**8504.08**
Services included in capitation:	1231.52
Services not included in capitation:	7272.56
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	*Capi-tation*	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Housing Stabilization Transition Service Total:							***1571.44***
Housing Stabilization Transition Service	☐	*15 minutes*	*26*	*4.00*	*15.11*	***1571.44***	
Personal Emergency Response System Total:							***37629.90***
Personal Emergency Response System	☐	*monthly*	*126*	*11.00*	*27.15*	***37629.90***	

GRAND TOTAL:	***25512247.32***
Total: Services included in capitation:	*3694573.95*
Total: Services not included in capitation:	*21817673.37*
Total Estimated Unduplicated Participants:	***3000***
Factor D (Divide total by number of participants):	***8504.08***
Services included in capitation:	*1231.52*
Services not included in capitation:	*7272.56*
Average Length of Stay on the Waiver:	*339*