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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. **Program Title:**
Supports Waiver

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

D. **Amendment Number:**

E. **Proposed Effective Date:** *(mm/dd/yy)*
01/01/15
Approved Effective Date of Waiver being Amended: 07/01/14

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
*Making changes to the unit of service for the following services: Day Habilitation, Prevocational Services, and Supported Employment.

*Adding of two reserved capacity groups: 1) High School to Work and 2)Priority

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A – Waiver Administration and Operation	
☐ Appendix B – Participant Access and Eligibility	
☐ Appendix C – Participant Services	

Component of the Approved Waiver	Subsection(s)
☐ Appendix D – Participant Centered Service Planning and Delivery	
☐ Appendix E – Participant Direction of Services	
☐ Appendix F – Participant Rights	
☐ Appendix G – Participant Safeguards	
☐ Appendix H	
☐ Appendix I – Financial Accountability	
☐ Appendix J – Cost-Neutrality Demonstration	

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

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

Specify:

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

1. Request Information (1 of 3)

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

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

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: LA.0453
Draft ID: LA.006.02.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/14
Approved Effective Date of Waiver being Amended: 07/01/14

1. Request Information (2 of 3)

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

- ☐ **Hospital**

Select applicable level of care

Hospital as defined in 42 CFR §440.10
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

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

☐ **Nursing Facility**

Select applicable level of care

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

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

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

1. Request Information (3 of 3)

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

◉ **Not applicable**

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

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

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

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:
☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The goals of the Supports Waiver are as follows:
• To create options and provide meaningful opportunities that enhance the lives of men and women with developmental disabilities through vocational and community inclusion.
• To promote independence for individuals with a developmental disability who are age 18 or older while ensuring health and welfare through a system of participant safeguards.
• To increase high school to community transition resources by offering supports and services to those 18 years and older.

The objectives of the Supports Waiver are as follows:
• To allow the participant choice in selecting providers and support coordination agencies through Freedom of Choice forms;
• To develop an individualilzed plan of care that embraces the participant's self-determination and is responsive to the participant's specific needs and preferences;
• To promote independence for participants through the provision of services meeting the highest standards of quality and national best practices, while ensuring health and welfare through a comprehensive system of participant safeguards;
• Offer an alternative to institutionalization through the provision of an array of services and supports that promote community inclusion and independence by enhancing and not replacing existing informal networks;
• Support participants in exercising their rights and sharing responsibility for their programs regardless of the method of service delivery;
• Utilize personal outcome interviews and standardized assessment tools to assist in the creation of participant-centered service plans that reflect participant's needs and preferences; AND
• To allow the participant the choice between institutional care and home and community-based services.

Supports Waiver services are accessed by contacting the the Local Governing Entity (LGE),formerly known as the Human Services Authorities and Districts (HSA/D), Systems Entry Unit to determine if the applicants meet the Developmental Disability (DD) criteria. The LGE is responsible for this role. When criteria are met, the applicant's name is placed on the DD Request for Services Registry (RFSR) until a Supports Waiver offer is made available. The RFSR is one system with separate lists for the Supports Waiver (SW) and the New Opportunities Waiver (NOW), with the appropriate date request for each waiver. The RFSR contains data regarding the individual's date of request specific to the SW. When the applicant is offered the Supports Waiver, he/she may accept or deny the offer. If the applicant accepts the offer, he/she chooses a support coordination agency through the Freedom of Choice (FOC) process. Then, the support coordination agency offers FOC of direct service provider(s). Once the applicant is found eligible for waiver services, his/her plan of care (POC) must be approved by the LGE. All services must be prior authorized and delivered in accordance with the approved POC.

The Department of Health and Hospitals (DHH) Bureau of Health Services Financing (BHSF) is the Single State Medicaid Agency which maintains administrative and supervisory oversight of the Supports Waiver. Oversight and administrative authority within BHSF is carried out through the Medicaid Program Support and Waivers (MPSW), formerly known as the Waiver Compliance Section (WCS), with assistance from other sections within BHSF. OCDD has a Memorandum of Understanding with the Human Services Authorities and Districts, also known as the LGE's which specifies the roles and responsibilities of each party and the methods used to ensure the operating agency performs delegated waiver operations and administrative functions in accordance with the approved waiver application, rules, and policies.

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 Department of Health and Hospitals (DHH) receives input through a taskforce workgroup comprised of stakeholders such as, waiver participants, parents and/or family members, other DHH agencies, providers of services, State and Regional Offices, Supports and Services Center, professional and grassroots advocacy groups, and other interested parties. On an informal basis, OCDD reviews comments and suggestions from stakeholders that impact this waiver.

In April, 2011, the State formed an Employment First Workgroup that was comprised of self- advocates, family members, stakeholders and other state agencies that have provided input on the changes to be made to improve Employment outcomes in Louisiana amongst the DD population. Several groups including the DD Council, the ARC of Louisiana and the Advocacy Center were groups that had spoken out and asked for improvements and changes to be made to support employment for individuals with DD.

In the fall of 2011, the state hosted nine public forums, one in every region of the state to introduce the State's Employment First Initiative, explain how the State would be making changes to ensure that employment was a priority outcome for individuals with DD and to obtain input regarding the changes that would be taking place over the next five years. Simultaneously, the State also conducted an online survey for those unable to participate in person at a public forum or for those wanting to comment anonymously.

The State has provided trainings over the past three years to various stakeholder organizations, to families and participants with DD regarding Employment First and how services will change and to other various stakeholder organizations.

Participants and their families were assured that their services would not be lost, that the services that they receive such as prevocational, supported employment and day habilitation, may look different, including time limits on certain services, but in the end the State wanted to assist more participants in going to work.

The State is currently going through a systems transformation and has held monthly stakeholder meetings to discuss the changes that are taking place and gathering input and feedback into the process so that when the transformation is completed , a better system will be in place for the participants.

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

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

7. Contact Person(s)

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

Last Name: Levelle

First Name: Jeanne

Title: Section Chief

Agency: Bureau of Health Services Financing

Address: 628 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: Jeanne.Levelle@la.gov

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

Last Name: Thomas

First Name: Mark A.

Title: Assistant Secretary

Agency: Office for Citizens with Developmental Disabilities

Address: 628 North Fourth Street

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

City: Baton Rouge

State: Louisiana

Zip:

70821

Phone:

(225) 342-0095 **Ext:** ☐ **TTY**

Fax:

(225) 342-8823

E-mail:

mark.thomas@la.gov

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Louisiana**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

   The waiver is operated by the State Medicaid agency.

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

   The Medical Assistance Unit.

   Specify the unit name:

   (Do not complete item A-2)

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

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

(Complete item A-2-a).

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

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

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

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

BHSF through MPSW facilitates monthly meetings with OCDD and the Medicaid data contractor to discuss waiver issues and problems. At these meetings, solutions are formed, corrective action agreed upon, and follow-up implemented by OCDD as necessary. In addition, meetings are held at least quarterly with MPSW, the Medicaid Director or Deputy Director, the OCDD Assistant Secretary, and other designated staff to discuss problems, issues, planning, concerns, and any other matters concerning the waiver as necessary.

Variance meetings are also held monthly with OCDD, DHH's Division of Health Economics, and MPSW to review financial utilization and expenditure performance of all OCDD' waivers.

BHSF retains oversight of all waiver operations and administrative functions performed by the operating agency. In furtherance of carrying out the interagency agreement and under the authority of BHSF, the following activities occur:
1. Disseminate information concerning the waiver to potential enrollees – Frequent and regular meetings are held between OCDD and MPSW where proposed changes are discussed prior to OCDD developing drafts. Drafts are submitted to MPSW for our input and suggestions. Revisions are made accordingly until a final draft is completed for Medicaid review and approval. As needed, MPSW will participate in training conducted by OCDD when implementing changes with providers. BHSF develops and distributes brochures, flyers, and other informational material regarding available programs to Louisiana citizens. BHSF oversees the website information, as well as communication distribution via Help Lines regarding waiver eligibility and policy administration.
2. Assist individuals in waiver enrollment BHSF maintains supervision by approving the process for entry of individuals into the waiver through the OCDD regional office and post-linkage procedures carried out by OCDD and the contractors.
3. Manage waiver enrollment against approved limits BHSF receives bi-weekly reports from the Medicaid data contractor which identify the number of participants receiving services, exiting the waiver, and offered a waiver opportunity. This report is reviewed with OCDD during the bi-weekly meetings. Other reports which are received by both BHSF and OCDD include waiver closure summary reports, admissions summary reports, level of care intake, acute care utilization, and waiver expenditures.
4. Monitor waiver expenditures against approved limits OCDD is responsible for completing the annual CMS -372 report utilizing MMIS data and submitting it to BHSF for review and approval. Quarterly meetings with BHSF, OCDD, and the Division of Health Economics are held to discuss waiver administration and to review financial participation and budget forecasts in order to determine if any adjustments are needed.
5. Conduct level of care evaluation activities OCDD is responsible for submitting aggregated reports on level of care assurances to BHSF on a quarterly basis. In addition, the Medicaid data contractor submits reports to BHSF on the number of initial enrollees who meet the required level of care prior to receipt of services and the number of participants who received an annual redetermination at least annually.
6. Review participant plans of care to ensure that all waiver requirements are met OCDD is responsible for submitting aggregated reports on plan of care assurances to BHSF on an established basis. In addition, the Medicaid data contractor submits reports to BHSF on the number of plans of care updated/revised at least annually, number of participants who received all types of services specified in their plan of care, and number of participants who received services in the amount, frequency, and duration specified in the plan of care.
7. Prior authorize waiver services BHSF oversees OCDD exercise of prior authorization activities through reports issued by the Medicaid data contractor. Meetings are held with BHSF, OCDD, and the Medicaid data contractor to discuss any issues relevant to prior authorization. BHSF ensures waiver services are authorized and utilized in conformance to waiver requirements through the annual monitoring conducted during the licensing surveys and random audits of the plans of care. System changes related to claims processing and prior authorization can only be facilitated by BHSF.
8. Determine waiver payment amounts or rates - BHSF determines all waiver payment amounts/rates in collaboration with OCDD, Division of Health Economics, and as necessary the Rate & Audit section.
9. Conduct training and technical assistance concerning waiver requirements – The Medicaid fiscal intermediary conducts annual training related to Medicaid requirements with prior approval from BHSF on all material. BHSF also reviews all OCDD waiver policies and satisfaction survey results as it relates.

DHH Health Standards Section conducts all licensing surveys of providers that render waiver services.

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

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

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

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

There are several cross agency workgroups which have been formed in order improve the Quality Improvement System within all Medicaid Waivers.

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

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

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

Appendix A: Waiver Administration and Operation

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

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   The Medicaid data contractor tracks data on plans of care, such as date the initial plan is submitted and approved, date the annual plan of care is approved, date the plan of care is received by the LGE; tracks support coordination, provider services, waiver slots both occupied and vacant, tracks information on time lines, offerings of waiver opportunities and linkages to support coordination agencies, tracks the waiver certification process; provides prior authorization functions; maintains the Request for Services Registry; issues freedom of choice forms to the participant/family members to select a support coordination agency, collects data from providers, and provides notification to 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 Department of Health and Hospitals (DHH) Bureau of Health Services Financing (BHSF), with input from the operating agency, is responsible for assessing the performance of the data contractor, support coordinator, and fiscal agent.

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 Contractor – The Medicaid monitor tracks/reviews data reports generated by the Medicaid Data Contractor on a quarterly basis. The reports include tracking volume, timelines, and deliverables for the previous months. Reports also include 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 month's 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. The MPSW staff meets with the Contractor at least monthly to review performance and adherence to the terms of the contract.

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. **Performance Measures**

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
A.a.i.1. Number and percent of agreed upon waiver assurance trend and data reports that were submitted timely, as defined by contract/other agreement, by the operating agency/contractor, separated by entity. Numerator = number of reports submitted timely; Denominator = total number of reports due.

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

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

Performance Measure:
A.a.i.2. 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, to applicants on the Request for Services Registry. Numerator = number of appropriately made offers to applicants on the RFSR; Denominator = total number of waiver offers made.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
A.a.i.3. Number and percentage of waiver participants whose services did not exceed the service limits authorized on their plan of care. Numerator = number of plans for which services did not exceed the service limits specified in the approved plan of care; Denominator = total number of plans.

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:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
A variety of mechanisms are employed by MPSW to ensure all issues with the operating agency/contractor's performance are remediated:

1. MPSW meets with contractors and operating agency staff on an on-going, established basis to discuss delegated functions, pending issues, and remediation plans. Individual issues requiring remediation will be referred back to the operating agency and/or contractor for correction. MPSW will monitor to ensure remediation activities are completed to address any identified areas of non-compliance within 30 days of notification. Systemic issues requiring remediation will be identified and discussed at the Cross Waiver (which includes staff from MPSW, OAAS, and OCDD) and Medicaid Oversight Review Team (which includes Medicaid staff) meetings. A plan for remediation and person responsible will be developed for each item identified. Remediation strategies and progress towards correction will be reviewed and documented at the next scheduled meeting.
2. MPSW, the Medicaid Director or Deputy Director,the OCDD Assistant Secretary, and other pertinent staff meet on at least a quarterly basis to discuss any pending issues and remediation plans.
3. Memorandums are sent from BHSF to OCDD to ensure all necessary leadership is informed of the support actions needed to correct problems or make improvements.

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

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

c. Timelines

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

◉ **No**

Yes

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☑ Intellectual Disability or Developmental Disability, or Both					
	☑	Autism	18		☑
	☑	Developmental Disability	18		☑
	☑	Intellectual Disability	18		☑
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

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

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

◉ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an

amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- ☐ **The participant is referred to another waiver that can accommodate the individual's needs.**
- ☐ **Additional services in excess of the individual cost limit may be authorized.**

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

- ☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	2500
Year 2	2500
Year 3	2500
Year 4	2500
Year 5	2500

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	2050
Year 2	2050
Year 3	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
	2050
Year 4	2050
Year 5	2050

Appendix B: Participant Access and Eligibility

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

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

Not applicable. The state does not reserve capacity.

The State reserves capacity for the following purpose(s).

Purpose(s) the State reserves capacity for:

Purposes	
Individuals exiting high school and going to work (School To Work)	
Priority	

Appendix B: Participant Access and Eligibility

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

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

Individuals exiting high school and going to work (School To Work)

Purpose *(describe):*

Fifty opportunities exist to support individuals who are at least 18 years of age, exiting high school and want to go to work in an individual, integrated job in the community.

Describe how the amount of reserved capacity was determined:

Individuals must meet all of the following criteria to be considered for participation in the fifty (50) "Transition from School to Work" opportunities.

Individuals with a developmental disability must:
1. Be 18 years of age
2. Be Medicaid eligible
3. Be eligible for state developmental disability services
4. Meet ICF/DD level of care.
5. Individuals must be exiting the school system
6. Must desire an individual, integrated job in the community.
7. Will require supports and/or services to obtain and/or maintain employment in the community, specifically Supported Employment services.

A. Each OCDD Human Services Authority or District/Local Governing Authority (LGE) is responsible for the prioritization of the "Transition from School to Work" opportunities that are assigned to their region. They will work cooperatively with the the local Transition Team to identify indivduals who meet the criteria.

The total number of individuals proposed is fifty (50).

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

Waiver Year	Capacity Reserved
Year 1	50
Year 2	50
Year 3	50
Year 4 (renewal only)	50
Year 5 (renewal only)	50

Appendix B: Participant Access and Eligibility

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

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

Priority

Purpose *(describe):*

Twenty (20) opportunities exist for individuals who meet the criteria. A "Priority" is defined as a change in circumstances to the individual and/or caregiver rendering the natural and community support system in place unable to meet the individual's needs and now requires services to sustain the individual in the community.

Describe how the amount of reserved capacity was determined:

Individuals must meet the following criteria for participation in the twenty (20) "Priority" opportunities. A "Priority" is defined as a change in circumstances to the individual and/or caregiver rendering the natural and community support system in place unable to meet the individual's needs and now requires services to sustain the individual in the community.

Individuals with a developmental disability must:

1. Be 18 years of age
2. Be Medicaid eligible
3. Be eligible for state developmental disability services
4. Meet ICF/DD level of care
5. Be designated by the OCDD Human Services Authority or District/Local Governing Authority (LGE) as meeting the criteria for a "Priority" opportunity.

A. Each OCDD Human Services Authority or District/Local Governing Authority (LGE) is responsible for the prioritization of all "Priority" opportunities.

Determination of prioritization for a "Priority" opportunity is defined as follows:

1. Without requested supports, there is an immediate need for services due to out-of-home placement or homelessness or potential threat of out-of-home placement or homelessness due to a change in the individual's circumstances including but not limited to behavioral changes/challenges, problems with the law, or changes in their living arrangements or threat of losing their job.
2. Without requested supports, there is an immediate need for services due to out-of-home placement or homelessness or potential threat of out-of-home placement or homelessness due to a change in the care giver's circumstances including but not limited to health issues, death, changes in their job (i.e. working at night and now has to work in the day or having to get a job) or other changes that effect the current situation.
3. Without requested supports, there is an immediate need for services due to out-of-home placement or homelessness or potential threat of out-of-home placement or homelessness due to some other family crisis which leaves the individual with no care giver support available, such as abuse/neglect, or a second person in the household becomes disabled and must be cared for by the

same care giver, causing inability of the natural caregiver to continue necessary supports to assure health and safety of the individual.

The total number of individuals is twenty (20).

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

Waiver Year	Capacity Reserved
Year 1	20
Year 2	20
Year 3	20
Year 4 (renewal only)	20
Year 5 (renewal only)	20

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 the louisiana Register Volume 28, No. 09, September 20, 2002; Title 50 PUBLIC HEALTH-MEDICAL ASSISTANCE Part XXI. Home and Community Based Services Waivers, 11101. Waiver Availability

The order of entry is first come, first served from a statewide list arranged by date of application for Developmentally Disable (DD) Service. Families will be given a choice of accepting a slot in the Supports Waiver or remaining on the DD Request for Services Registry (RFSR), formerly known as the waiting list, hereafter referred to as "the registry". By accepting a SW opportunity, the person's name shall be removed from the registry. The number of participants is contingent on available funding.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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

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

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

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

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

  Select one:

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

  Specify percentage:

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

  Specify:

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

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

Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

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

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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 *(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 4)

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 4)

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 4)

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-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

◉ **The provision of waiver services at least monthly**

Monthly monitoring of the individual when services are furnished on a less than monthly basis

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

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

Directly by the Medicaid agency

◉ **By the operating agency specified in Appendix A**

By an entity under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

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

The Level of Care initial evaluation is completed by a Medical Certification Specialist 1 or 2.

The basic qualifications of the Medical Certification Specialist 1 (MCS-1) are as follows:

A baccalaureate degree plus three years of professional level experience in nursing, pharmacy, dietetics/nutrition, physical therapy, occupational therapy, or medical technology, or surveying health or social service programs or facilities for compliance with state and federal regulations. A current valid Louisiana license in one of the qualifying fields will substitute for the required baccalaureate degree. A master's degree in one of the qualifying fields will substitute for a maximum of one year of the required experience.

The MCS-2 must be followed by four years of professional level experience, rather than the three years of professional experience.

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

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

• The level of care criteria, 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 Medicaid Bureau of Health Services Financing (BHSF) form 90-L is used to determine the ICF/DD Level of Care. The individual's primary care physician must complete and sign and date the 90-L. This form must be completed at initial evaluation and annually thereafter to determine if the individual continues to meet the ICF/DD level of care. The 90-L is used in conjunction with the SOA to establish a level of care criteria and to complete the Plan of Care. The 90-L, SOA and plan of care documents are submitted to the LGE for staff review to assure that the applicant/participant meets/continues to meet the level of care criteria.

The Developmental Disability (DD) decision is made by 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 an SOD are informed of their rights to appeal and /or provided information regarding the appeals process. Please refer to Fair Hearings/Appeals Process as outlined in Appendix F-Section 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 Medicaid Bureau of Health Services Financing (BHSF) form 90-L is used to determine the ICF/DD Level of Care. The participant's primary care physician must complete and sign and date the 90-L. This form must be completed at initial evaluation and annually thereafter to determine if the participant still meets the ICF/DD level of care. The 90-L is used in conjunction with the SOA to establish a level of care criteria and to complete the plan of care. The 90-L, SOA and plan of care documents are submitted to the LGE for staff review to assure that the applicant/participant meets/continues to meet the level of care criteria.

The 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).

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

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

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

Specify the other schedule:

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

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

Specify the qualifications:

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

• The Medicaid Data Contractor has edits in the database system for tracking to ensure timely re-evaluations for the level of care.
Tracking is completed in a database for annual plans of care and annual redetermination of level of care, in cooperation with the waiver participant and his/her personal care physician, and is a component of support coordination.

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
B.a.i.a.1 Number and percentage of Waiver applicants that have been determined to meet the ICF/DD level of care prior to waiver certification. Numerator = number of applicants that have been determined to meet the ICF/DD level of care prior to waiver certification; Denominator = total number of applications reviewed in the sample.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
B.a.i.b.1 Number and percentage of waiver participants who received a Level of Care re-evaluation within 12 months of their initial or annual evaluation. Numerator = Number of waiver participants who received a timely Level of Care re-evaluations; Denominator = Total number of waiver participants due for re-evaluation reviewed in the sample.

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

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

		☑ **Representative Sample** Confidence Interval = 95%+/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measure:
B.a.i.c.1 Number and percentage of applicants/participants whose LOC determination has been completed following state procedure(s). Numerator= Number of applicants/participants whose LOC determination has been completed following state procedure(s); Denominator = Total number of completed LOC determinations reviewed in the sample.

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

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

Data Aggregation and Analysis:

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

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:

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: The LGE reviews applications to ensure that they contain all required information needed to conduct a LOC evaluation. Any incomplete, untimely, or inaccurate applications are returned by the LGE to the support coordinator for correction/clarification. The LGE staff will submit written documentation outlining the reason for the return to the support coordinator.

Performance Measure B.a.i.c.1: The LGE supervisor conducts a sample review of annual plans and initial plans to determine that there is a current Statement of Approval and a current 90L indicating that the LOC was accurately determined according to state procedures.

All aggregated data by the Operating Agency is submitted to MPSW on a quarterly basis for review and analysis.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Performance Measures B.a.i.a.1, B.a.i.c.1:
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, the OCDD State Office Performance Review Committee aggregates and reviews remediation data to assure that all cases needing remediation are addressed. Trends and patterns are identified in order to improve performance.
A variety of mechanisms are employed by BHSF/MPSW to ensure all remediation and appropriate action has been completed:
• MPSW reviews the quarterly aggregated quality reports and remediation reports provided by the operating agency to ensure all instances of non-compliance are remediated within thirty (30) days of notification.
• MPSW meets with operating agency staff on an established basis to discuss delegated functions, pending issues, and remediation plans. Systemic issues requiring remediation are identified and discussed at the Cross -Waiver (which includes staff from MPSW, OAAS, and OCDD) and Medicaid Oversight Review Team (which includes Medicaid staff) meetings. A plan for remediation and person responsible is developed and person responsible is assigned for each item identified. Remediation strategies and progress towards correction are reviewed and documented at the next scheduled meeting until the item is closed out.
• MPSW, the Medicaid Director or Deputy Director, the OCDD Assistant Secretary, and other pertinent staff meet on at least a quarterly basis to discuss any pending issues and remediation plans.

• Memorandums are sent from BHSF to OCDD to ensure all necessary leadership is informed of the support actions needed to correct problems or make improvements.

ii. **Remediation Data Aggregation**

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

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

c. **Timelines**

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

◉ **No**

Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

• The Department of Health and Hospitals, 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.