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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The waiver application was updated to reflect current quality monitoring processes/procedures, update terminology, and to allow for the development of a provisional plan of care for the purpose of expediting service authorizations/service delivery for initial waiver enrollees.

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*):

Coordinated System of Care (CSoC) Severely Emotionally Disturbed (SED) Children's Waiver

C. Type of Request: renewal

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**

Waiver Number:LA.0889.R02.00
Draft ID: LA.029.02.00

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

Regular Waiver

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

07/01/22

Approved Effective Date: 07/01/22

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

☒ **Hospital**

Select applicable level of care

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

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

Psychiatric care within a general hospital and inpatient psychiatric hospital for individuals under age 21 as provided in 42 CFR 440.160.

○ **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:

N/A

○ **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:

Louisiana Healthy Louisiana and CSoC Waiver approved by CMS effective 12/1/15.

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 Coordinated System of Care (CSoC) Waiver is designed to provide specialized home and community-based services to members with mental health needs who would otherwise require the level of care of an inpatient psychiatric hospital or nursing facility. The waiver is based on an overarching system of care philosophy and approach that is guided by the following values:
- family driven
- youth guided
- culturally and linguistically competent
- home and community-based
- strength-based
- individualized
- integrated across systems (bringing agencies, schools, and providers together to work with families)
- connected to natural helping networks
- data driven and outcome oriented
- unconditional care

The CSoC Waiver is operated by the Office of Behavioral Health through a Memorandum of Understanding with the Single State Medicaid Agency (Louisiana Bureau of Health Services Financing); both agencies fall under the Louisiana Department of Health. Waiver services are provided by a single PIHP through a contract with the Office of Behavioral Health.

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:

In accordance with 42 CFR 441.304, the State's intention to renew the Coordinated System of Care (CSoC) waiver was published in Louisiana's major Louisiana newspapers on November 19, 2021. The entire waiver application was also made available on the OBH website for public review and comments for a period of 30 days prior to the waiver submission to CMS for approval. The public comment period runs from November 19, 2021 - December 19, 2021. No comments were received by LDH.

The department's public notice and input process for this renewal consisted of the following:

The State published the public notice in the eight major daily newspapers of the state with the largest circulation. They were published in the following cities: Lafayette, Baton Rouge, New Orleans, Alexandria, Shreveport, Monroe, Lake Charles, and Houma.

The public notice appeared in the Legal Ad section of the hard copy newspapers and was published electronically on the Louisiana Press Association website. Within the public notice, we provided information on how to access the waiver application and provide comments and feedback in both hard copy and electronic forms.

In addition, Louisiana notified the federally recognized tribes in Louisiana of the State's intention to renew the Coordinated System of CAre (CSoC) waiver on November 19, 2021. The deadline for receipt of all written comments is December 19, 2021. No comments were received by LDH.

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: Bennett

First Name: Brian

Title: Section Chief, Medicaid Program Supports and Waivers

Agency: Louisiana Department of Health

Address: 628 N. 4th Street

Address 2:

City: Baton Rouge

State: **Louisiana**

Zip: 70821-9030

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

Fax: (225) 342-9508

E-mail: Brian.Bennett@la.gov

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

Last Name: Grace

First Name: Candace

Title: Director of Quality Management

Agency: Office of Behavioral Health

Address: 628 N. 4th Street

Address 2:

City: Baton Rouge

State: **Louisiana**

Zip: 70802-4049

Phone: (225) 342-8670 **Ext:** ☐ **TTY**

Fax: (225) 342-5066

E-mail: Candace.Grace@LA.GOV

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Brian Bennett

State Medicaid Director or Designee

Submission Date: Jun 16, 2022

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

Last Name: Bennett

First Name: Brian

Title: Section Chief, Medicaid Program Support and Waivers

Agency: Louisiana Department of Health

Address:

628 N. 4th Street

Address 2:

City: Baton Rouge

State: **Louisiana**

Zip: 70802

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

Fax: (225) 342-9505

E-mail: Brian.Bennett@LA.GOV

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

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

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

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

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

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

Louisiana assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. Louisiana completed all milestones related to Systemic Assessment and Remediation, Site-specific Assessments and Remediation, Heightened Scrutiny, and Non-Compliant Settings, and will implement any required changes upon approval of the Statewide Transition Plan.

Louisiana's Statewide Transition Plan (STP) received initial approval on March 3, 2017. Louisiana submitted addendums to the STP that addressed issues that CMS identified before the state could receive final approval. The STP and its addendum is currently under review with CMS and may be accessed via the OBH website http://www.ldh.la.gov/index.cfm/page/1342.

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:

Office of Behavioral Health

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 Louisiana Department of Health (LDH) is the cabinet-level "umbrella" agency for the major publicly-funded health and long term care programs in Louisiana. The administering, operating, and licensing agencies for the Coordinated System of Care (CSoC) are located within LDH. Within LDH, the Bureau of Health Services Financing (BHSF) is responsible for the administration of the state Medicaid program and is the administering agency for the CSOC. The Office of Behavioral Health (OBH) serves as the operating agency for the CSoC and is the policy and program agency for people with mental illness and addictive disorders. The Health Standards Section (HSS) serves as the licensing agency for the state and is responsible for the licensing and oversight of providers. All agencies reporting to the same cabinet Secretary which enables close collaboration, coordination, and oversight.

The BHSF, and the operating agency, OBH, have a Memorandum of Understanding (MOU) defining the responsibilities of each. The MOU is to be reviewed yearly and updated as necessary. BHSF and OBH 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. Medicaid oversight of operating agency performance is facilitated through the following committees:
1. LDH Variance Committee – meets at least quarterly to review financial utilization and expenditure performance of all OBH waivers. Members are composed of representatives from OBH, Division of Health Economics, and Medicaid.

2. Coordinated System of Care Interdepartmental Monitoring Team - meets at least quarterly with the specific purpose to ensure proper oversight of the OBH operated HCBS Medicaid programs. Goals are to review current performance reports, determine need for new activities concerning quality and oversight in waiver programs and ensure adequate remediation enforcement. Quality recommendations or issues which cannot be resolved at this level are placed on the agenda with OBH and Medicaid leadership staff which include section chief, assistant deputies and assistant secretary level staff on an as needed basis to provide technical assistance guidance, and direction.

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. Participant waiver enrollment – BHSF maintains supervision by approving the process for entry of individuals into the waiver through the OBH.

2. Waiver enrollment managed against approved limits –This function is accomplished through the review of ongoing data reports received through OBH and the PIHP. These data reports include the number of participants enrolled in the waiver, exiting the waiver offered a waiver opportunity, waiver closure summary, admissions summary, level of care intake, acute care utilization, and waiver expenditures. BHSF and OBH will meet at least quarterly to review data reports.

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

4. Level of care evaluation – OBH is responsible for submitting aggregated reports on level of care assurances to BHSF on an established basis.

5. Review participant service plans- OBH is responsible for submitting aggregated reports on plan of care assurances to BHSF on an established basis.

6. Prior authorization of waiver services - To ensure that payments are accurate for the services rendered, OBH monitors and oversees the requirements of the provider through the prior authorization process and the approved plan of care (POC). The PIHP is responsible for the prior authorization functions as it relates to payments to their contracted service providers including waiver providers. The WRAP Around Agencies develop the Plan of Care. Once developed, that same information is submitted for prior authorization to the PIHP. The Wraparound Agencies provide the PIHP with the participant's Child and Adolescent Needs and Strengths (CANS) and Individualized Behavioral Health Assessment IBHA results. The PIHP prior authorizes services according to the authorized service plan. OBH formally submits service plan performance measure data, analysis and remediation actions to BHSF as specified Appendix D: QIS sub-assurance c.

7. Utilization management –Reports are generated quarterly from the PIHP's database which will include: number of participants who received all types of services specified in their service plan and number of participants who received services in the amount, frequency, and duration specified in the service plan. OBH reviews these reports for trends and patterns of under-utilization of services. OBH formally submits performance measure data, analysis and remediation actions to BHSF as specified in Appendix D: QIS sub-assurance d.

8. Qualified provider enrollment - If a provider requests participation in the PIHP to provide waiver services, the provider must undergo a credentialing process with the PIHP. If the PIHP determines the waiver provider meets its credentialing requirements, which parallel the provider qualifications outlined in this waiver application, the PIHP will contract with the provider. OBH formally submits performance measure data, analysis and remediation actions to BHSF as specified in Appendix C: QIS.

9. Establishment of a statewide rate methodology - BHSF determines all minimum waiver payment amounts/rates in collaboration with OBH, Division of Health Economics, and as necessary the Rate & Audit section.

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

11. Quality assurance and quality improvement activities - OBH submits performance measure data, analysis and remediation actions to Medicaid as specified in the waiver QIS.

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 Prepaid Inpatient Health Plan (PIHP) is a contracted entity responsible for serving as the single point of entry for CSoC level of care evaluations and contact with Medicaid eligibility staff; providing a Member Handbook and other informational material to members on the services, grievance and appeal procedures, member rights and protections etc.; operating a grievance and appeal system in accordance with state and federal requirements; resolving issues related to member health and welfare, quality of care, or access to care; provider recruitment, contracting, and monitoring; providing training to wraparound agencies/facilitators and contracted providers; utilization management; quality management; and operation of a 24/7 member line to address issues and urgent service authorization requests.

Regional Wraparound Agencies (WAAs) are contracted with the PIHP to provide level of care evaluations/assessments, treatment planning for provision of services, and ongoing monitoring to ensure implementation of the plan, member health and safety, member access to care, and quality of care/satisfaction.

○ **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 Office of Behavioral Health and the Bureau of Health Care Financing (Medicaid).

Appendix A: Waiver Administration and Operation

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

The State assesses the performance of the PIHP through routine analysis of PIHP reports, deliverables, and performance metrics to ensure requirements and any associated performance standards are adequately met; quality reviews conducted by the external quality review organization on no less than an annual basis; and waiver operation meetings held on a routine basis, typically monthly.

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

	Ongoing	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:
AA1 Numerator: Number of members whose plan of care shows evidence that their setting meets HCBS requirements Denominator: Total number of members

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

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

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: PIHP	☒ **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: PIHP	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA2 Numerator:Number of CSoC providers who meet the HCBS setting requirements
Denominator:Total number of credentialed providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
PIHP credentialing/re-credentialing data system

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

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

b. Methods for Remediation/Fixing Individual Problems

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

OBH reviews and analyzes HCBS setting performance measure data to ensure the compliance with the state and federal regulations. If compliance falls below 100%, OBH reviews remediation actions taken on an individual basis to ensure appropriate resolution. If compliance falls below the 86% threshold, OBH will require the PIHP to develop a quality improvement plan which must include a root-cause analysis, proposed interventions and associated timelines for addressing low performance, and methods and associated timelines for evaluating the success of the plan.

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: PIHP	☐ **Annually**
	☐ **Continuously and Ongoing**

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☒ **Mental Illness**					
	☒	**Mental Illness**	18	20	☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☒	Serious Emotional Disturbance	5	17	

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:

Beginning at age 19 and continuing until the member approaches the age of 21 years, a continuum of services will be identified on the plan of care by the Child and Family Team (CFT) process to aid in the transition process. The wraparound facilitator collaborates with the member and his/her parent/guardian in the development and implementation of the transition plan, which includes a referral to the member's respective Healthy Louisiana plan to determine eligibility for adult community-based services and mental health supports. In addition, if the members meets the criteria for another home and community-based waiver program, a referral is made to the respective operating agency.

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)

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:

The plan of care is developed for the member during the application process concurrently with waiver eligibility. Health and welfare are assured by a combination of Medicaid services, waiver services, school services, and other supports received through natural and community resources. Individuals who are not permitted to enroll in the waiver due to the individual cost limit will receive a notice of action and be permitted to appeal directly through the State Fair Hearing process.

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

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

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

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

☒ **Other safeguard(s)**

Specify:

The member, parent/legal guardian, and other members of the Child and Family Team (CFT) may convene a meeting at any time the member's needs, risk level, or circumstances significantly change. If the CFT determines there is a need for increased intensity of services, the PIHP may approve a time-limited increase (less than 90 days) in the intensity of services. If the CFT determines the member continues to need an increased intensity of services, the member will be re-evaluated by a CANS-certified LMHP. The PIHP will review the results of the assessment and authorize services based on LDH-approved medical necessity criteria. The member will be referred/transitioned to a higher level of care if determined eligible.

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	5557
Year 2	5557
Year 3	5557
Year 4	5557
Year 5	5557

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	2900
Year 2	2900
Year 3	2900
Year 4	2900
Year 5	2900

Appendix B: Participant Access and Eligibility

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

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

◉ **Not applicable. The state does not reserve capacity.**

○ **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

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

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

◉ **The waiver is not subject to a phase-in or a phase-out schedule.**

○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

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

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

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

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

A waiting list is not anticipated to be put in place; however, if a waiting list should occur, entrance parameters would be on a first-come, first serve basis.

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:

- Medicaid Optional targeted low-income children (42 CFR 435.229)
- Parents and other caretaker relatives (42 CFR 435.110)
- Pregnant women (42 CFR 435.116)
- Children under age 19 (42 CFR 435.118)
- All reasonable classification of children (42 CFR 435.222)
- Foster care and adoption subsidy (42 CFR 435.145)
- Adoption assistance (42 CFR 435.227)
- Children eligible under the Chaffee Foster Care Independence Act of 1999 (1902 a) (10)(A)(ii)(XVII) and 1905(w))
- Former foster care children (1902(a)(10)(A)(i)(IX))

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

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

Specify percentage:

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

Specify dollar amount:

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

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

  Select one:

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

    (*select one*):

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

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

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

    Specify percentage:
  - ( ) **Other standard included under the state Plan**

    Specify:

- ( ) **The following dollar amount**

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

  Specify:
- ( ) **Other**

  Specify:

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

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

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

  Specify:

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

- (●) **Not Applicable (see instructions)**
- ( ) **AFDC need standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

  Specify dollar amount: [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- ( ) **The amount is determined using the following formula:**

  Specify:
- ( ) **Other**

  Specify:

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

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

Select one:

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

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

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

(*select one*):

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

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

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

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

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

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

● **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

○ **Other**

Specify:

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

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

Select one:

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

● **The state does not establish reasonable limits.**

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **The following dollar amount:**

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

  Specify formula:
- ○ **Other**

  Specify:

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

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

Explanation of difference:

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

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

Select one:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The state does not establish reasonable limits.**
- ○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

Quarterly

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

- ○ **Directly by the Medicaid agency**
- ◉ **By the operating agency specified in Appendix A**
- ○ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

○ **Other**
Specify:

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

Physician (MD or DO) or Licensed Mental Health Practitioner (LMHP) licensed to practice independently. LMHPs include medical psychologists, licensed psychologist, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapist, licensed addiction counselors, and advanced practice registered nurses (APRN). APRNs must be nurse practitioner specialists in adult psychiatric and mental health, and family psychiatric and mental health, or certified nurse specialists in psychosocial, gerontological
psychiatric mental health, adult psychiatric and mental health, and child-adolescent mental health.

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.

Level of care is determined using the Child and Adolescent Needs and Strengths (CANS) Comprehensive Multisystem Assessment in conjunction with a bio-psychosocial assessment. The CANS generally assesses the member in the following areas: Problem Presentation; Risk Behaviors; Functioning; Care Intensity required to support functioning; Caregiver Capacity; and Strengths. The CANS Comprehensive Multisystem Assessment includes the following domains: Behavioral/Emotional Needs, Child Risk Behaviors, and Life Domain Functioning. The CANS Level of Care Decision Model recommends the appropriate level of care for treatment services for members, which is automatically calculated based on the behavioral health algorithm when a comprehensive CANS or reassessment is completed. Medical eligibility requires that the applicant be: (1) A child under 18 years of age with serious emotional disturbance (SED) or a youth aged 18 through 21 years with serious mental illness (SMI); (2) Assessed as requiring hospital or nursing facility level of care, meaning, but for the availability and provision of waiver services, the applicant would fit the medical criteria to be served in a hospital, based on the BHSF nursing facility LOCET criteria or hospital criteria per R.S. 46: 153 (Louisiana Register, Volume 21, No. 6, 6/20/1995). The criteria contain a two-fold definition: severity of need and intensity of service required, both of which must be met. The PIHP staff that serve on the independent review team will review medical, psychiatric, and psychosocial evaluations, including the CANS as well as any additional information supplied by the child/youth, family, or the Wraparound Facilitator.

The initial level of care is completed by a CANS-certified LMHP when the applicant/member scores positive on the Brief CANS and is referred for CSoC services through an interview with the member and his/her parent/guardian. The initial level of care must be completed within 30 days of the referral and every 180 days thereafter or more frequently if the member's risk factors or needs significantly change. In addition, a CANS is completed at the time the member is discharged from the CSoC program.

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.

The State contracted with John Lyons, creator of the CANS assessment tool, to compare the nursing facility LOCET criteria request for BHSF, which is the institutional precertification level of care criteria, and the hospital certification requirements with the CANS and found that all nursing facility and hospital certification requested information and values are included in the CANS. The CANS has demonstrated strong reliability across users and validity relative to other assessments as well as in predicting treatment and level of care needs. The tool is currently used to support level of care decisions in at least 10 other states and had demonstrated satisfactory utility in those applications. The CANS recommendation for level of care determination is automatically calculated based on the behavioral health algorithm for members/applicants at the same levels as Louisiana nursing facility and hospital levels of care when the comprehensive CANS or reassessment is completed. This results in comparability across eligibility determinations that are fully comparable to the BHSF nursing facility and Louisiana hospital certification level of care criteria.

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:

Initial Evaluation
-Member is between ages 5 through 20 years old and has a Serious Emotional Disturbance.
-CANS assessment completed by a CANS-certified LMHP which indicates member meets minimum scores for inpatient psychiatric hospital level of care based on the CANS LOC Decision Model.
-Member meets financial eligibility requirements as determined by Medicaid.

Reevaluations are conducted using the CANS assessment tool and other available clinical records every 6 months or more often based on significant changes in the member's needs, risk level or circumstances.

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 State requires the PIHP to have appropriate systems in place to track level of care timelines, as well as to alert Wraparound Agencies of said timelines. The OBH Quality Monitoring Team analyzes reports related to the level of care assurance to ensure timeliness of level of care evaluations.

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:

PIHP and Wraparound Agencies

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
LOC1: Numerator: Number of initial members who meet the level of care requirements prior to receipt of services Denominator: Total number of initial members enrolled in the waiver

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

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

		Sample Confidence Interval =
☒ **Other** Specify: PIHP	☐ **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: PIHP	☒ **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:
LOC2: Numerator: Number of members whose level of care determination form was completed timely, as required by the State Denominator: Total number of members

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: PIHP	☐ **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: PIHP	☒ **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:
LOC4: Numerator: Number of level of care decisions made in accordance with waiver requirements for the minimum level of care Denominator: Total number of level of care decisions reviewed

Data Source (Select one):
Other

If 'Other' is selected, specify:
PIHP data system

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

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

Performance Measure:
LOC3: Numerator: Number of members whose level of care determination was made by a qualified evaluator Denominator: Total number of members included in the sample

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

OBH reviews and analyzes level of care performance measure data to ensure compliance with the sub-assurances. If compliance falls below 100%, OBH reviews remediation actions taken to address issues on an individual-level to ensure appropriate resolution. If compliance falls below the 86% threshold, OBH will require the PIHP to develop a quality improvement plan which must include a root-cause analysis, proposed interventions and associated timelines for addressing non-compliance, and methods and associated timelines for evaluating the success of the plan.

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: PIHP	☒ **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 wraparound facilitator informs members and their parent/guardians of the feasible alternatives under the waiver and ensure they are provided with a choice of either institutional or home and community-based services at the time a waiver offer is made (as documented on the Case Management Choice and Release of Information Form).

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The forms are maintained by the PIHP and at the physical office of the Wraparound Agency.

Appendix B: Participant Access and Eligibility

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

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

The PIHP is required to make real-time oral interpretation services available free of charge to both potential members and current members, and notify members that oral interpretation is available for any language free of charge. The PIHP is also required to ensure that translation services are provided for all written member material for any language that is spoken as a primary language for four percent or more of members or potential enrollees. Materials must be available to members at no charge.

In addition, the LDH publishes all Medicaid application forms in English, Spanish, and Vietnamese; these forms are also available in alternative format upon request.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Independent Living/Skills Building**		
Other Service	**Parent Support and Training**		
Other Service	**Short-Term Respite**		
Other Service	**Youth Support and Training**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Independent Living/Skills Building

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
13 Participant Training	13010 participant training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Independent Living/Skills Building (ILSB) services assists members who are or will be transitioning to adulthood with support in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to be successful in the domains of employment, housing, education, and community life and to reside successfully in home and community settings. ILSB activities are provided in community settings and in partnership with members to help them arrange for the services they need to become employed, access transportation, housing, and continuing education. In addition, ILSB services can be utilized to train and cue normal activities of daily living and instrumental activities of daily living; however, housekeeping, homemaking (shopping, child care, and laundry services), or basic services solely for the convenience of the member receiving services are not covered.
Services are based on each member's strengths, interests/preferences, skills, and goals, as included on the person-centered plan of care.
Examples of community settings could encompass (not an all-inclusive listing): a grocery or clothing store (teaching the member how to shop for food, or what type of clothing is appropriate for interviews); unemployment office (assist in seeking jobs, assisting the member in completing applications for jobs); apartment complexes, (to seek out housing opportunities); laundromats, (how to wash clothes); bus depot (accessing public transportation). These services may be provided in other community setting as identified through the plan of care.
Transportation provided between the member's place of residence and other services sites or places in the community is included in the rate paid to providers of this service.

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

Services shall not duplicate any other Medicaid State Plan service or other services otherwise available to the member at no cost.

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

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

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transition Coordination Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Independent Living/Skills Building

Provider Category:

Agency

Provider Type:

Transition Coordination Agency

Provider Qualifications

License *(specify):*

Transition Coordination Agency
Licensed as Behavioral Health Services Provider
LAC 48:I.Chapter 56.

Certificate *(specify):*

Other Standard *(specify):*

Supervision shall be provided to the Transition Coordinator to provide back up, support, and/ or consultation. A LMHP shall be available at all times to provide back up, support, and/ or consultation.

Employ Transition Coordinators who have a high school diploma or equivalent.
-Must be 21 years of age and have a minimum of 2 years experience working with children with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of work experience and education with one year of education substituting for one year of experience;
-Pass criminal background checks and motor vehicle screens.
-Completion of an approved training in the skills area(s) needed by the transitioning youth according to a curriculum approved by the OBH prior to providing the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Upon contracting and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Parent Support and Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10050 peer specialist
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Parent Support and Training provides training and support necessary to ensure engagement and active participation of the family in the treatment planning process, and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Support and training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the member (e.g., parenting children with various behavior challenges), which involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the member in relation to their mental illness and treatment; development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for the member's symptom/behavior management; assisting the family in understanding various requirements of the waiver process, such as the crisis/safety plan and plan of care process; training on understanding the member's diagnoses; understanding service options offered by service providers; and assisting with understanding policies, procedures and regulations that impact the member (e.g., training on system navigation and Medicaid interaction with other child serving systems). The specialist may also conduct follow-up with the families regarding services provided and continuing needs. In addition, the specialist attends meetings with the family and assist in helping family members to effectively contribute to planning and accessing services including assistance with removing barriers.

For the purpose of the CSoC, family is defined as the primary care giving unit and is inclusive of the wide diversity of primary care giving units in our culture. Family is a biological, adoptive or self-created unit of people residing together consisting of adult(s) and/or child(ren) with adult(s) performing duties of parenthood for the child(ren). Persons within this unit share bonds, culture, practices and a significant relationship. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family. For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, sibling, children, relatives, grandparents, guardians, foster parents or others with significant attachment to the individual. Services may be provided individually or in a group setting.

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

-Parent Support and Training will not duplicate any other Medicaid State Plan Service or other services otherwise available to the recipient at no cost.
-The Parent Support Specialist must be supervised by a person meeting the qualifications of a Parent Support Supervisor.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Family Support Organizations

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Parent Support and Training

Provider Category:
Agency
Provider Type:

Family Support Organizations

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

-Have a high school diploma or equivalent.
-Must be 21 years of age and have a minimum of 2 years experience living or working with a child with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of life/work experience and education with one year of education substituting for one year of experience; (preference is given to Parents or caregivers of children with SED)
-Certification and completion of Parent Support Training according to a curriculum approved by the OBH prior to providing the service.
- Pass criminal background check and motor vehicle screens.
-A LMHP shall be available at all times to provide back up, support, and/or consultation.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Upon contracting and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Short-Term Respite

HCBS Taxonomy:

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

09 Caregiver Support	09012 respite, in-home

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

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

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

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

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

Service Definition *(Scope):*

Short Term Respite Care provides temporary direct care and supervision for the member in the member's home/relative's home or a community setting that is not facility-based (i.e., not provided overnight in a provider-based facility). The primary purpose is to provide relief to family members/caregivers, help de-escalate stressful situations and provide a therapeutic outlet for the child. Respite may be either planned or provided on an emergency basis. Normal activities of daily living are considered to be included in the content of the service when providing respite care and cannot be billed separately, which include: support in the home/ after school/or at night, transportation to and from school/medical appointments/ or other community based activities, and/or any combination of the above. The cost of transportation is also included in the rate paid to providers of this service.

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

-Short Term Respite Care pre-approved for the duration of 72 hours per episode with a maximum of 300 hours allowed per calendar year. These limitations can be exceeded through prior authorization by the PIHP or inclusion in the PIHP-approved plan of care.
-Short Term Respite Care will not duplicate any other Medicaid State Plan Service or other services otherwise available to recipient at no cost.
-The member must be present when Short Term Respite services are provided.
-Short-Term Respite may not be provided simultaneously with Crisis Stabilization services.
-Medicaid federal financial participation (FFP) will not be claimed for the cost of room and board.
-Short Term Respite services provided by or in an IMD are not covered.
-The provider must be at least three years older than an individual under the age of 18.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supervised Independent Living (SIL) Agency
Agency	Personal Care Attendant
Agency	Respite Care Services Agency
Agency	Child Placing Agency (Therapeutic Foster Care)
Agency	Crisis Receiving Center

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Short-Term Respite

Provider Category:

Agency

Provider Type:

Supervised Independent Living (SIL) Agency

Provider Qualifications

License *(specify):*

Licensed as a HCBS provider; Personal Care Attendant (PCA) agency; R.S. 40:2120.1 et seq. and Louisiana Administrative Code (LAC) 48:I.Chapter 50

Certificate *(specify):*

Other Standard *(specify):*

Completion of state approved training according to a curriculum approved by the OBH prior to providing the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Upon contracting and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Short-Term Respite

Provider Category:

Agency

Provider Type:

Personal Care Attendant

Provider Qualifications

License *(specify):*

Licensed as a HCBS provider; Personal Care Attendant (PCA) agency; R.S. 40:2120.1 et seq. and Louisiana Administrative Code (LAC) 48:I.Chapter 50

Certificate *(specify):*

Other Standard *(specify):*

LDH Standards of Participation; LR Vol. 29, No. 9, September 20, 2003
Completion of state approved training according to a curriculum approved by the OBH prior to providing the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Upon contracting and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Short-Term Respite

Provider Category:

Agency

Provider Type:

Respite Care Services Agency

Provider Qualifications

License *(specify):*

Respite Care Services Agency/ Center Based Respite
Licensed as a Home & Community Based Service (HCBS) provider, Louisiana R.S. 40:2120 et seq. Louisiana Administrative Code (LAC) 48:I.Chapter 50

Certificate *(specify):*

Other Standard *(specify):*

Completion of state approved training according to a curriculum approved by the OBH prior to providing the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Upon contracting and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Short-Term Respite

Provider Category:

Agency

Provider Type:

Child Placing Agency (Therapeutic Foster Care)

Provider Qualifications

License *(specify):*

Licensed as a Child Placing Agency by Department of Child and Family Services; R.S. 46:1401-1424

Certificate *(specify):*

Other Standard *(specify):*

Completion of state approved training according to a curriculum approved by the OBH prior to providing the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Upon contracting and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Short-Term Respite

Provider Category:

Agency

Provider Type:

Crisis Receiving Center

Provider Qualifications

License *(specify):*

Licensed per Revised Statutes (RS) 28:2180.14 and Louisiana Administrative Code 48:I.Chapters 53 and 54

Certificate *(specify):*

Other Standard *(specify):*

Completion of state approved training according to a curriculum approved by the OBH prior to providing the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Upon contracting and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Youth Support and Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10050 peer specialist
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

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

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

Service Definition *(Scope):*

Youth Support and Training services are member-centered support services that provide the training and support necessary to ensure engagement and active participation of the member in the treatment planning process, and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Youth Support and Training services are recovery focused and designed to promote skills for coping with and managing psychiatric symptoms while facilitating the utilization of natural resources and the enhancement of community living skills. Activities included must be intended to achieve the identified goals or objectives as set forth in the member's person-centered plan. Services can be provided individually or in a group setting with the member present. The majority of Youth Support and Training contacts must occur in community locations where the member lives, works, attends school and/or socializes. This service may include the following components:
-Helping members to develop a network for information and support from others who have been through similar experiences
-Assisting members to regain the ability to make independent choices and take a proactive role in treatment including discussing questions or concerns about medications, diagnoses or treatment with their clinician.
-Assisting members to identify and effectively respond to or avoiding identified precursors or triggers that maintain or increase functional impairments.
-Assist members with the ability to address and reduce the following behaviors: reducing reliance on Youth Support and Training over time, rebellious behavior, early initiation of anti-social behavior (e.g., early initiation of drug use), attitudes favorable toward drug use (including perceived risks of drug use), antisocial behaviors toward peers, contact with friends who use drugs, gang involvement, and intentions to use drugs.

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

-Local Education Agencies may not provide this service.
-Limit of 750 hours of Youth Support and Training services per calendar year. This limit can exceeded be when medically necessary through prior authorization.
-The Youth Support Specialist must be supervised by a person meeting the qualifications for a Youth Support Supervisor and a Licensed Mental Health Professional.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Family Support Organizations

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Youth Support and Training

Provider Category:

Agency

Provider Type:

Family Support Organizations

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must be at least 18 years old and have a high school diploma or equivalent. Certification in the State of Louisiana to provide the service, which includes criminal and professional background checks, and completion of a standardized basic training program approved by the OBH. Self-identify as a present or former child recipient of behavioral health services.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Upon contracting and annually thereafter

Appendix C: Participant Services

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

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

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

Check each that applies:

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

C-1-c.

☒ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

The PIHP conducts all case management functions compliant with managed care treatment planning requirements at 42 CFR 438.208(c)using Wraparound Facilitators employed by State certified Wraparound Agencies.

Appendix C: Participant Services

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

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

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

◉ **Yes. Criminal history and/or background investigations are required.**

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

The PHIP must screen all network providers to determine whether they have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General. To help make this determination, the PHIP shall conduct screenings to comply search at minimum the following sites: Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) http://exclusions.oig.hhs.gov/; Louisiana Adverse Actions List Search (LAALS) https://adverseactions.dhh.la.gov/; The System for Award Management (SAM) https://www.sam.gov/index.html/; National Practitioner Data Bank http://www.npdb-hipdb.hrsa.gov/index.jsp; and Other applicable sites as may be determined by LDH. The PHIP shall continue to conduct a search of these websites monthly to capture exclusions and reinstatements that have occurred since the previous search. The PHIP must submit a monthly attestation to LDH Program Integrity certifying checks have been completed.

Provider agencies with direct service providers must conduct criminal background checks, sex offender checks, motor vehicle screens and Medicaid exclusion checks on all prospective employees including non-licensed personnel who may have direct access to individuals served at the time an offer of employment is made.

The provider must review the Department of Health and Human Services' Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the LDH State Adverse Actions website prior to hiring or contracting any employee or contractor that performs services that are compensated with Medicaid/Medicare funds, including but not limited to licensed and unlicensed staff, interns and contractors. Once employed, the lists must be checked once a month thereafter to determine if they have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General.

Criminal background checks, including sex offender registry status, must be conducted on all prospective employees of licensed agencies and providers who may have direct access to individuals served prior to allowing the employee to work directly with individuals receiving HCBS services. The scope of the history of background checks is mandated by State law and is conducted by the Louisiana State Police or their designee which includes a nationwide level check. PIHP licensed contract agencies must comply with this law. This includes direct care positions, administrative positions and other support positions that have contact with individuals served.

The PIHP reviews the provider agency's policy on criminal record checks and motor vehicle screens, as well as Medicaid exclusion screening verification at the time of initial credentialing of the agency and re-verifies agency credentials at a frequency determined by the PIHP, no less than every three years. Annually, the PIHP reviews agency personnel practices to ensure that there is documentation of the criminal background check, motor vehicle screens and Medicaid exclusion screens for a sample of employees hired by each provider agency.

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

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

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

The state of Louisiana maintains a registry of direct service workers for the purpose of maintaining and tracking any findings of abuse, neglect and/or misappropriation that has been placed. The Louisiana Department of Health (LDH), Health Standards Section manages the Direct Service Worker Registry located on the Louisiana Adverse Action web site. Provider agencies who contract with the PIHP must screen all prospective direst service workers. Once employed, the provider must screen all employees once a month thereafter to determine if there is a finding that an employee or contractor has abused, neglected an individual being supported, or misappropriated the individual's property or funds.

The PIHP verifies the provider agency's Medicaid exclusion screening of all direct care staff at the time of initial credentialing. Annually, the PIHP reviews agency personnel practices to ensure that there is documentation of the Louisiana Adverse Action website screens for a sample of employees hired by each provider agency.

Direct Service Worker Registry https://ldh.la.gov/index.cfm/page/3779.

Appendix C: Participant Services

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

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

Appendix C: Participant Services

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

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

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

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

☐ **Self-directed**

☐ **Agency-operated**

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

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

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

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

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

Services may be provided by the member's family, provided the member does not live in the same residence as the family member, and as long as the family member is not a legally responsible relative.
Family members that may provide services include parents of an adult child, siblings, grandparents, aunts, uncles, and cousins. The family member must become an employee of the provider agency contracted with the PIHP and must meet the same standards as direct support staff that are not related to the member.

○ **Other policy.**

Specify:

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

LDH operates a concurrent 1915 (b)/(c) waiver that waives participant choice and allows for the selective contracting of behavioral health providers. The contracted PIHP will subcontract with any willing qualified provider meeting the provider qualifications as outlined in the 1915(c) waiver. The 1915(b) waiver allows the State to waive freedom of choice. The 1915(b) requires that the PIHP meet accessibility criteria per state guidelines. However, per federal requirements at 42 CFR 438.6, 42 CFR 438.12, 42 CFR 438.206, 42 CFR 438.230, 42 CFR 438.214, and SMM 2087.4, the PIHP must evaluate the prospective provider's ability to perform the activities to be delegated prior to contracting with the entity. The PIHP must have a written agreement with the provider that specifies the activities and report responsibilities delegated to the subcontractor and provides for revoking delegation or imposing other sanctions if the provider's performance is inadequate. The PIHP must monitor the providers' performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. The PIHP must identify deficiencies or areas for improvement, and take corrective action and terminate the provider if progress if not made to correct the deficiency or area for improvement. The PIHP is required to associate with other providers of mental health services not included in the PIHP network when the needs of enrolled members are not met by contracted service behavioral health providers. In all contracts with health care professionals, the PIHP must have written policies and procedures to ensure: selection and retention of providers; credentialing and recredentialing requirements; and nondiscrimination. The PIHP must regularly demonstrate to the LDH and the EQRO that its providers are credentialed. The PIHP's provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
QP2: Numerator: Number of providers continuously meeting licensing and training requirements Denominator: Total number of non-initial providers

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

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

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

Performance Measure:
QP1: Numerator: Number of providers initially meeting licensing and training requirements prior to furnishing waiver services Denominator: Total number of initial providers

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

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

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

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

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

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

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

Performance Measure:
QP3: Numerator: Number of non-licensed direct care staff of providers that meet State requirements Denominator: Total number of non-licensed direct care staff of providers included in the sample

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

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

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

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

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

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

Performance Measure:
See QP1 and QP2

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

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

OBH reviews and analyzes qualified provider performance measure data to ensure compliance with the sub-assurance. Individual instances of non-compliance may signal the need for operational changes to the PIHP's processes to ensure appropriate front-end checks are in place for identifying and flagging providers who have not meet training, licensing, or certification requirements. As such, if compliance falls below 100%, the PIHP will be required to submit a quality improvement plan which includes a root-cause analysis, proposed interventions and associated timelines for addressing non-compliance, and methods and associated timelines for evaluating the success of the plan.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

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

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

CSoC members are served in settings that fully comport with the home and community-based setting requirements. Most members reside with their families, as the purpose of this waiver is to prevent out-of-home placement and divert members from institutional levels of care. In addition, all CSoC services are provided in home and community-based settings.

The State assesses all settings, residential and non-residential, through provider assessment surveys, participant surveys, and onsite reviews to ensure compliance with the home and community-based setting requirements as outlined in the State's Statewide Transition Plan. On an ongoing basis, the State ensures continued compliance with these regulations by surveying participants at least once every six months to ensure their HCBS experience comports with the new regulations and by monitoring providers' compliance through the certification review process and other review assessments. The PIHP is required to collect information during the enrollment process to ensure the proposed setting comports with the setting requirement and is required to report to OBH any settings discovered that are not in compliance with the setting requirements.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Plan of Care

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

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

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

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

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

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

☐ **Social Worker**
Specify qualifications:

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

The PIHP conducts all case management functions compliant with managed care treatment planning requirements at 42 CFR 438.208(c) using wraparound facilitators employed by OBH-certified Wraparound Agencies. Wraparound facilitators must meet the following requirements:
-Bachelor's-level degree in a human services field or bachelor's-level degree in any field, with a minimum of two years of full-time experience working in relevant family, children/youth or community service capacity. Relevant alternative experience may substitute for the bachelor's-level degree requirement in individual cases, subject to approval by LDH;
-Completion of the required training for Wraparound facilitators; and
-Pass a Louisiana criminal history background check and motor vehicle screens.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The Child and Family Team (CFT) includes the member, parent/legal guardian/caretakers, behavioral health providers, and other individuals chosen by the member/family. The member and his/her parent/legal guardian/caretakers have the primary role of identifying appropriate goals, strengths, preferences and needs which inform the development of the person-centered plan of care and crisis plan. All members of the CFT are able to provide input to assist with identifying appropriate services, including type, frequency and duration, and identify natural and community supports that are built into the plan of care. The wraparound facilitator plays a role in this process by facilitating the plan of care development through documentation of the decisions made by the CFT, facilitating the overall meeting, and assuring that all members of the team have the opportunity to participate. The member and his/her parent/legal guardian/caretakers have the ability to request a CFT meeting at any time should needs or circumstances change.

In addition, the Family Support Organization's Parent Support Specialists and Youth Support and Training Specialists provide training and support necessary to ensure engagement and active participation of the family (based on member/family choice) in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. This training focuses on increasing the family's ability to provide a safe and supportive environment in the home and community for the member; assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the member in relation to their mental illness and treatment; development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for the member's plan of care process; interpreting choice offered by service providers; and assisting with understanding policies, procedures and regulations that impact the member.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Once the applicant screens positive on the CANS Brief Screening, the PIHP makes the determination that the applicant is presumptively eligible for the waiver and PIHP sends concurrent written referrals to the Wraparound Agency and a CANS-certified LMHP to initiate the enrollment and assessment process. The member is enrolled in the 1915(c) waiver if the level of care and Medicaid financial eligibility criteria is met (and based on member choice). If the child does not meet clinical and financial eligibility, the appropriate non-Medicaid funding source will be billed and the member will not be enrolled in the wavier. See Appendix G for a description of the appeal rights that any non-Medicaid member will be offered.

a. During the initial meeting, the wraparound facilitator meets with the family to provide information on the CSoC program/services, offer freedom of choice between waiver and institutional services, complete a strengths and cultural discovery, develop a provisional plan of care and identify potential members of the Child and Family Team (CFT), such as natural supports and formal supports/providers; the provisional plan of care and freedom of choice form are due within 30 days of referral. Following the initial meeting, the wraparound facilitator convenes the CFT to develop the initial plan of care within 45 days of receipt of referral from the PIHP; the plan of care is based on the information obtained from the strengths and cultural discovery, CANS Comprehensive Assessment, and feedback from the member, his/her parent/caregivers and CFT. The member and his/her parent/caregivers may request a CFT meeting at any time or when their needs/circumstances change.
b. The CANS Comprehensive Multisystem Assessment is completed by an CANS certified LMHP through an interview with the member and his/her parent/caregivers. Through this assessment, the LMHP explores the member and his/her family's strengths and needs using a person-centered, collaborative approach. The CANS facilitates linkage between the assessment process and development of an individualized plan of care, including the development of measurable and achievable goals, which are created in partnership with the member and his/her family.
c. The wraparound facilitator provides information on the services available through the waiver and other delivery systems (e.g., therapy and medication management services available through the Medicaid State Plan) to the member and parent/caregivers during the initial meeting. The Child and Family Team process also incorporate naturally occurring supports, such as extended family members, child/family friends and individuals from the family's social network. Formalized services are included in the plan of care but do not supplant existing or identified natural supports.
d. System of Care values align with home and community-based services and include strengths-based, family-centered, culturally respectful and community based. These core values are the foundation for the training that is provided to HCBS providers and wraparound agencies. In keeping with these core values, the wraparound process is a participant-driven process whereby the member and the parents of caregivers of the member direct the membership of their Child and Family Team. Membership is reflective of individuals the family has identified as a source of support, individuals in the community that may be able to provide support in the future through natural supports, and providers of service. All services are coordinated through the Child and Family Team's development of the plan of care, which identifies the member's preferences, goals, and needs.
e. The wraparound facilitator guides the plan of care development process by assisting the CFT in identifying available resources and services to meet the member's needs, and ensuring said services are implemented. The wraparound facilitator monitors plan of care implementation in partnership with the CFT on a monthly basis.
f. The Plan of Care identifies the assigned task and person responsible for implementing the identified support to attain each plan of care goal. The plan of care also includes a crisis plan, which identifies potential crisis, action steps (strategies), and the person(s) responsible to mitigate the risk.
g. The plan of care is updated at a minimum on a semi-annual basis through the CFT process. However, a CFT meeting can be convened at any time in which needs or circumstances have changed or the member and parents or caregivers of the member feel it is warranted, or the needs of the member require the Child and Family Team to meet on a more frequent basis to best coordinate care.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Each member is required to have a crisis plan, based on the individualized needs and preferences of the member and his/her parent/caregivers, which is developed in conjunction with the plan of care by the wraparound facilitator and CFT. The crisis plan identifies potential crisis (risks) based on the CANS assessment and feedback from the member/parent/caregivers, appropriate interventions (strategies to mitigate risks), action steps as a backup plan if the crisis cannot be averted, and contact information for all parties, which are developed through the CFT process. The action steps may involved contacting natural supports and/or wraparound facilitator, calling a crisis line, or accessing short-term respite, crisis intervention/stabilization services, or other supports/resources. Families are provided a copy of their crisis plan, along with the plan of care.

In addition, the plan of care includes an individualized backup plan which includes the action steps to follow in case of an emergency or the failure of a formal support person to provide services when scheduled.

The crisis plan and backup plan may be updated when requested by the member/family or based on significant changes to member needs, circumstances, or risks.

The PIHP is required to provide 24/7 member service line that is readily accessible to members and their families to address crises and arrange for services. In addition, the wraparound facilitator must also be available to assist in the event of a crisis or if a formal support person fails to provide services when scheduled.

Training provided to wraparound facilitators highlight the need to identify different levels of intervention on a crisis plan, the different stages of crisis, and how a crisis may be defined differently by each family.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Members and their parent/caregivers are offered freedom of choice of providers within the PIHP network and may change providers as often as desired. This information is specified in the Member Handbook which is provided to members upon enrollment in the waiver and included on the PIHP's website.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Plans of care are submitted to the PIHP to verify requirements are met and for issuance of service authorizations. The State Medicaid Agency monitors the plan of care process through audits conducted by the Medicaid-contracted external quality review organization and through routine reporting by the PIHP on plan of care-related measures.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

○ **Other schedule**

Specify the other schedule:

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

☐ **Medicaid agency**

☐ **Operating agency**

☐ **Case manager**

☒ **Other**

Specify:

Records are maintained at the PIHP and the Wraparound Agency for at least six years per Louisiana Revised Statute 40:1299.96.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The wraparound facilitator is responsible for monitoring the implementation of the plan of care and member health and welfare through at least monthly contacts with the member/parent/caregiver. Specifically, plan of care monitoring includes ensuring the member has access to services included in the approved plan of care, services are meeting the needs and preferences of the member, effectiveness of the crisis plan, and member health and welfare in the community. In addition, the wraparound agency convenes a meeting with the CFT every 90 days to monitor progress on goals identified in the plan of care.

b. Monitoring Safeguards. *Select one:*

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

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
POC2: Numerator: Number of members whose plan of care include supports and services consistent with assessed health needs, including risks Denominator: Total number of members included in the sample

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

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

Performance Measure:
POC1: Number and percent of members whose plan of care reflects supports and services necessary to address the member's goals # of members whose plan of care reflects supports and services necessary to address the member's goals / Total number of members included in the sample

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

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

Agency		
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +,-5%
☒ **Other** Specify: PIHP	☐ **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: PIHP	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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

Performance Measures

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

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

Performance Measure:
POC3: Number and percent of members who participated in the plan of care development, as documented by the member's and parents/caregiver's signature on the plan of care # of members who participated in the plan of care development / total # of members included in the sample

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

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

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

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

Performance Measures

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

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

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

Performance Measure:
POC5: Numerator: Number of members whose plans of care were updated when their needs changed Denominator: Total # of members included in the sample

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

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

Performance Measure:
POC4: Numerator: Number of members whose plans of care were updated timely
Denominator: Total number of members

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

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

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

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to

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

Performance Measure:
POC6: Numerator: Number of members who received waiver services in the type, amount, duration, and frequency specified in the plan of care Denominator: Total number of members

Data Source (Select one):
Other
If 'Other' is selected, specify:
Program logs; record reviews to validate data reported by WAAs

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

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

Performance Measures

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

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

Performance Measure:
POC8: Number and percent of members who received information on available waiver services, as documented by the member/authorized representative's signature on the State-approved form. # of members who received information on available waiver services / total number of members included in the sample

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

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

☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +,-5%
☒ **Other** Specify: PIHP	☐ **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: PIHP	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measure:
POC7: Number and percent of members given a choice among service providers, as documented by the member's/authorized representative's signature on the State-approved form # of members given a choice among service providers / total number of members included in the sample

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

OBH reviews and analyzes plan of care performance measure data to ensure compliance with the sub-assurances. If compliance falls below 100%, OBH reviews remediation actions taken to address issues on an individual-level to ensure appropriate resolution. If compliance falls below the 86% threshold, OBH will require the PIHP to develop a quality improvement plan which must include a root-cause analysis, proposed interventions and associated timelines for addressing non-compliance, and methods and associated timelines for evaluating the success of the plan.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

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

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

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

All waiver applicants/members are notified of their right to request a fair hearing by the PIHP in accordance with 42 CFR 431 Subpart E and 42 CFR 438 Subpart F. Upon enrollment into the waiver, the PIHP sends each member a Member Handbook, which includes information on appeal rights and processes. For members and their families with limited literacy, the wraparound facilitator verbally explains appeal rights during the initial meeting. In addition, the PIHP is required to give members any reasonable assistance in completing forms and taking other procedural steps. This includes but is not limited to providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. When an applicant/member is denied participation in the waiver or if services are denied, terminated, suspended or reduced, the PIHP sends a written notice to the applicant/member explaining the reason for the adverse action, instructions on how to file an appeal, the time frame for making the request, information on continuation of services during the appeal process (if applicable) and contact information for questions and concerns. The notice also contains information on the state fair hearing rights and processes, and toll free numbers for the Medicaid agency and for requesting free legal assistance. Notices of termination, suspension or reduction are mailed to the member a minimum of 10 days before the proposed date of action.

Members must exhaust themselves of the appeal process offered by the PIHP before accessing the state fair hearing process. If the member or their authorized representative, or provider (when applicable) with prior written consent, requests an appeal, the PIHP gathers information on the case and schedules the appeal with an independent reviewer who had no prior involvement in making the adverse decision. The PIHP sends a written notice of the reconsideration decision to the individual, along with detailed instructions on requesting a state fair hearing. Applicants/members may then request a state fair hearing with the Louisiana Division of Administrative Law (DAL) (http://www.adminlaw.state.la.us/). Members may continue to receive services up through the final decision by the state fair hearing, if requested by the member, and as long as the member meets the appeal deadlines and the original period covered by the authorization has not expired.

BHSF eligibility staff utilize the Adequate Notice of Home and Community Based Services (Waiver) Decision Form 18-W to notify applicants/members by mail if they have not been approved for Medicaid coverage for the CSoC waiver due to financial ineligibility. A separate page is attached to this form entitled “Your Fair Hearing Rights,” which contains information on how to request a fair hearing, how to obtain free legal assistance, and a section to complete if the applicant/member would like to request a state fair hearing. All administrative hearings are conducted in accordance with the Louisiana Administrative Procedure Act, La. R.S. 49:950 et seq. Any party may appear and be heard at any appeals proceeding through an attorney at law or through a designated representative.

Copies of all notices and documentation of appeal decisions are maintained by the PIHP. The administrative law judge in the Division of Administrative Law maintains records on the state fair hearing and records on the formal hearing.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

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

The PIHP has an internal dispute resolution system as required by 42 CFR 438 Subpart F. The internal system encompasses both an appeal process, as described in Appendix F-1, for addressing an adverse benefit determination and a grievance process for addressing grievances (complaints). Adverse benefit determinations include the denial or limited authorization of a requested service, reduction, suspension or termination of a previously authorized service, denial of payment for a service, failure to provide services in a timely manner as specified in the risk contract and failure to take action within the timeframes specified in the contract for resolving grievances and appeals.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

PIHP, with oversight by the OBH Quality Monitoring Team.

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

The PIHP is required to accept and dispose of all grievances in accordance with 42 CFR 438 Subpart F. The PIHP must dispose of each grievance and provide notices as expeditiously as the member's health condition requires, within State-established timeframes not to exceed 30 days from the date the grievance was filed. The PIHP is required to report grievances filed, action taken by the PIHP to resolve grievance, final disposition resolution, and dates of all actions on a monthly basis. This report is received by the OBH Quality Monitoring Team to ensure adherence to state and federal requirements, and overall member satisfaction and quality of care/access to care.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- ◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ○ **No. This Appendix does not apply** *(do not complete Items b through e)*

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

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

The PIHP is responsible for reporting critical incidents involving members to the OBH and ensuring staff, providers, and wraparound facilitators report incidents to the appropriate protective service agency and licensing agency, as applicable. The Louisiana Children's Code, Title 6, Article 612, mandates the responsibility for investigating reports of child abuse and/or neglect to the Department of Children and Family Services (DCFS), specifically the Child Protection Investigation (CPI) Program. DCFS has jurisdiction in any setting when the alleged victim is less than 18 years of age and the alleged perpetrator is considered a caregiver (family or paid); this jurisdiction is in addition to that of any appropriate licensing regulatory agency.

For youth 18-21, the Bureau of Adult Protective Services is designated by the Louisiana Department of Health as the agency responsible for carrying out the mandate of Louisiana Revised Statute 14:403.2 with regard to adults with disabilities and emancipated minors who live in unlicensed and non-regulated settings and for managing the Adult Protective Services programs in LDH administered facilities. Adult Protective Services (APS) serves adults ages 18-59 and emancipated minors who have a mental or physical disability that substantially limits their ability to provide for their own care or protection and who live in the community either independently in their own home or with the help of others or in any other place that is not licensed by a governmental regulatory agency. APS is responsible for investigating and arranging for services to protect adults with disabilities who are at risk of abuse, neglect, exploitation, or extortion.

Types of Critical Events:
1. Abuse (child/youth): Any one of the following acts which seriously endanger the physical, mental, or emotional health and safety of the child:
-The infliction, attempted infliction, or, as a result of inadequate supervision
-The allowance of the infliction or attempted infliction of physical or mental injury upon the child by a parent or any other person.
-The exploitation or overwork of a child by a parent or any other person.
-The involvement of the child in any sexual act with a parent or any other person, or
-The aiding or toleration by the parent or the caretaker of the child's sexual involvement with any other person or of the child's involvement in pornographic displays, or any other involvement of a child in sexual activity constituting a crime under the laws of this state. (Children's Code Article 603)
2. Abuse (adult): The infliction of physical or mental injury on and adult by other parties, including, but not limited to, such means as sexual abuse, exploitation, or extortion of funds, or other things of value, to such an extent that his health, self-determination, or emotional well-being is endangered. (Louisiana Revised Statutes 14:403.2).
-Exploitation (adult): The illegal or improper use or management of an aged person's or disabled adult's funds, assets or property, or the use of the person's or disabled adult's power of attorney or guardianship for one's own profit or advantage. (Louisiana Revised Statutes 14:403.2).
3. Extortion (adult): The acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority. (Louisiana Revised Statutes 14:403.2).
4. Neglect (child/youth): The refusal or unreasonable failure of a parent or caretaker to supply the child with necessary food, clothing, shelter, care, treatment, or counseling for any injury, illness, or condition of the child, as a result of which the child's physical, mental, or emotional health and safety is substantially threatened or impaired. This includes prenatal illegal drug exposure caused by a parent, resulting in the newborn being affected by the drug exposure or withdrawal symptoms. (Children's Code Article 603)
5. Neglect (adult): The failure, by a care giver responsible for an adult's care or by other parties to provide the proper or necessary support or medical, surgical, or any other care necessary for his well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused. (Louisiana Revised Statutes. 14:403.2).

Mandatory reporters: Professionals who may work with children in the course of their professional duties and consequently are required to report all suspected cases of child abuse and neglect. Of the groups of mandated reporters defined in Children's Code Article 603, one group, Mental Health/Social Service Practitioner, includes all DCFS Child Protection Investigation Workers, Family Services Workers, and other agency social work staff in DCFS. (Children's Code Article 603). Mandatory reporters include any of the following individuals performing their occupational duties:
(a) "Health practitioner"
(b) "Mental health/social service practitioner".
(c) "Member of the clergy".
(d) "Teaching or child care provider".
(e) Police officers or law enforcement officials.

(f) "Commercial film and photographic print processor".
(g) Mediators appointed pursuant to Chapter 6 of Title IV.
(h) A parenting coordinator appointed pursuant to R.S. 9:358.1 et seq.
(i) A court-appointed special advocates (CASA) volunteer under the supervision of a CASA program appointed pursuant to Chapter 4 of Title IV.
Permitted Reporters (Children's Code Article 609) A person who has cause to believe that a child's physical or mental health or welfare is endangered as a result of abuse or neglect, and consequently may report the suspected case of abuse or neglect in accordance with Article 610.

Mandatory Reporting (child/youth)
In accordance with Louisiana Revised Statutes 40:2009.13 B reporting criteria, any person who has knowledge that a state law, minimum standard, rule, regulation, plan of correction promulgated by the department, or any federal certification rule pertaining to a health care provider has been violated, or who otherwise has knowledge that a youth has not been receiving care and treatment to which he is entitled under state or federal laws, may submit a report regarding such matter to the department.

"Any person having cause to believe that an adult's physical or mental health or welfare has been or may be further adversely affected by abuse, neglect, exploitation or extortion shall report to the adult protection agency or to law enforcement." (R.S 14.403.2 C and D)

Louisiana law mandates reporting of abuse and provides that persons who report in good faith have immunity from liability (unless they are themselves involved in the abuse). (Children's Code Article 611)

Any employee of LDH or an affiliate who has knowledge of possible abuse of a client, or who receives a complaint of abuse from a client or any other person, shall report in accordance with the provisions of this policy, applicable law, and the facility or program office's internal policy and procedures. If the person making the complaint is not an employee, e.g. a client, family member, visitor, etc., LDH staff shall assist the person in making a report, if necessary.

The timelines for reporting are: The provider must report all critical incidents immediately to the appropriate protective services agency. The provider must immediately forward a copy of the completed critical incident report to the PIHP within 24 hours of the incident occurrence or discovery.

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

Upon enrollment, the PIHP provides the member and family with a Member Handbook that outlines their rights, protections and the advocacy agencies who can educate and assist in the event of a concern. The wraparound facilitator discusses the rights and protections with the child/youth/legally responsible person as a component of the admissions process to the waiver. Opportunities for information training occur during routine monitoring.

Providers within the PIHP network are required to inform the child/youth of rights and protections through individual agency procedure. The PIHP will ensure that individual providers enrolled through the waiver are oriented on participant's rights and responsibilities, and grievance and appeal procedures that contain information on abuse and neglect.

The PIHP operates toll-free care line where the participant or his/her family can receive additional information or assistance, if needed. This line has the capacity to assist participants/families that are primarily Spanish speaking and/or hearing impaired. Child Protection Services are available day and night by calling the Child Protection hotline or the local parish Child Welfare office at the appropriate Child Protection phone number provided on the DCFS Website.

The Abuse and Neglect policy shall be thoroughly and annually explained to all employees and subcontractors of the PIHP as follows:

1. All new employees and subcontractors of the PIHP and affiliates who have direct contact with clients and/or who work in direct care facilities/programs shall be trained on all aspects of the policy. An acknowledgment of receiving these instructions shall be certified by the employee/subcontractor and maintained on file at the facility.
2. As soon as possible, but within 60 days after the signature of the contract/subcontract, the PIHP shall ensure that facility or provider meets the criteria established in this policy, and that staff who have contact with clients and/or who work in direct care facilities have received instruction on the content of the policy. Acknowledgment of the full training shall be certified and maintained on file with the facility/provider.
3. The PIHP shall have a continuing responsibility to ensure that appropriate staff/providers are currently informed of rules governing client abuse and neglect, and shall insure that each staff member receives training in the content of this policy not less than once each calendar year and more frequently if needed. Such training shall be documented and maintained on file at the facility.

A record shall be maintained by the PIHP for each employee/provider receiving orientation, annual training, or any other training required by this policy. This record shall, at a minimum, include the date that the training was provided, the name and classification of the individual conducting the training, the course title, and the number of hours of instruction received.

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

The PIHP is responsible for reviewing and reporting all critical events and incidents per the policy and procedure approved by the OBH.

All incidents of possible abuse involving LDH clients as alleged victims and/or LDH affiliate staff as the accused shall be reported immediately to the OBH as set forth in policy # 0102009 and APS procedures. APS may develop specific reporting procedures for individual facilities/programs within LDH.

In addition, State and Federal laws and regulations mandate reporting to the following agencies, based upon the age of the alleged victim, setting, and identity of the alleged abuser. These laws place the burden to report on the individual having knowledge or suspicion of the abuse. It is the responsibility of the facility/program manager to ensure that the appropriate external agencies listed below are notified in a timely manner.

1. The local Child Welfare Office for all allegations involving persons under 18 years of age, regardless of setting, where the accused is a formal or informal caregiver. Allegations of child abuse where the abuser is not a caregiver should be reported to local law enforcement. Reports should be made immediately or as soon as possible after knowledge. Dual reporting to both the local Child Welfare office of DCFS and the local or state law enforcement agency is permitted (Childrens Code (Article 610)).
2. The Health Standards Section of the LDH Bureau of Health Services Financing and Adult Protective Services for allegations involving persons who are receiving care in a facility licensed by that Section. This would include: persons residing in a licensed ICF-MR, a licensed nursing home, a licensed hospital, and other licensed health facility as defined in LA RS 40.2009.13. Reports should be made immediately or as soon as possible, but in no case later than 24 hours after knowledge.
3. Adult Protective Services (APS) for all allegations involving persons age 18-59, or emancipated minors, who are mentally, physically, or developmentally disabled when the person resides in a non-licensed setting or when a person residing in a licensed setting is allegedly abused by an accused who is not a staff member of the licensed facility. Reports should be made immediately or as soon as possible after knowledge.
4. The Department of Children and Family Services, Bureau of Licensing for all allegations where the accused is a staff person of a provider licensed by that agency. Reports should be made immediately or as soon as possible after knowledge.

For investigations, all employees of the Louisiana Department of Health (LDH) and affiliates including the PIHP and its providers are required to cooperate in any investigation of abuse. The agencies identified above as receiving external reports also have statutory or regulatory responsibility for investigating those reports and taking protective and/or regulatory action. Those agencies which are part of LDH shall carry out these functions as authorized by statute or regulation and according to their internal policies and procedures. In addition to the investigations already mentioned, allegations of abuse involving LDH clients where the accused is an employee of LDH or an affiliate will be investigated by the Bureau of Adult Protective Services. LDH offices which operate 24-hour facilities and programs associated with 24-hour facilities shall conduct investigative reviews and initiate appropriate corrective action for all reported allegations of abuse. Abuse and neglect reporting requirements for respite and crisis stabilization providers licensed under LDH are listed in RS 14:403.2 C & D and RS 40, 2009.13B. Should any allegations arise involving LDH clients which do not clearly fall under the jurisdiction of any agency identified above, the allegation may be investigated by the Bureau of Adult Protective Service.

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

The Department of Child and Family Services (DCFS) is responsible for the oversight of critical incident reporting and response for incidents involving abuse, neglect, extortion or exploitation involving children through a multi-agency Memorandum of Understanding.

The PIHP is required to report critical incidents involving waiver members on a monthly basis and conduct member record reviews using a representative, random sample to monitor member quality of care and health and welfare, including reporting of any identified critical incidents in accordance with state policy, on a quarterly basis. OBH analyzes reporting to identify issues that require further follow-up and trends that may indicate training needs and/or service enhancements.

Appendix G: Participant Safeguards

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

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

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

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

The PIHP is responsible for the development and dissemination of the Member Handbook which includes information regarding members' right to be free from restraints and seclusion. This Handbook is provided to members upon enrollment in the waiver and included on the PIHP's website. In addition, wraparound facilitators contact members on at least a monthly basis to monitor member health and welfare and the PIHP performs provider monitoring reviews, using a representative sample, on a quarterly basis to monitor unauthorized use of restraints.

The OBH analyzes reporting to identify issues that require further follow-up or need for additional training or system enhancements.

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

The PIHP is responsible for development and dissemination of a state-approved Member Handbook, which includes information about members' right to be free from restraints or seclusion. This handbook is provided to members upon enrollment in the waiver and included on the PIHP's website. In addition, wraparound facilitators contact members to monitor member health and welfare on at least a monthly basis and the PIHP conducts provider monitoring reviews, using a representative sample, to identify unauthorized use of restrictive interventions on a quarterly basis.

OBH analyzes reporting to determine if there are issues that require further follow-up or need for additional training or system enhancements.

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

The PIHP is responsible for development and dissemination of a state-approved Member Handbook, which includes information about members' right to be free from restraints or seclusion. This handbook is provided to members upon enrollment in the waiver and included on the PIHP's website. In addition, wraparound facilitators contact members to monitor member health and welfare on at least a monthly basis and the PIHP conducts provider monitoring reviews, using a representative sample, to identify unauthorized use of seclusion on a quarterly basis.

OBH analyzes reporting to determine if there are issues that require further follow-up or need for additional training or system enhancements.

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

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are

available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

b. Medication Management and Follow-Up

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

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

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

- ○ **Not applicable.** *(do not complete the remaining items)*
- ○ **Waiver providers are responsible for the administration of medications to waiver participants who**

cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

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

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

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

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

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

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

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

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

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States

methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
HW1: Numerator: Number of incidents involving A/N/E/D that were referred to the appropriate protective service agency for investigation within 24 hours of notification Denominator: Total # of incidents received

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

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

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

Performance Measures

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

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

Performance Measure:
HW2: Numerator: # of substantiated A/N/E/D incidents involving licensed/certified providers where appropriate follow was completed Denominator: Total # of A/N/E/D incidents involving providers

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
HW3: Numerator: # of participants who received information about how to report critical incidents Denominator: Total # of participants included in the sample

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

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
HW4: Numerator: # of critical incidents which did not involve the use of restraints or seclusion Denominator: Total number of incidents received

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

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

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
HW5: Numerator: # of participants who received coordination and support with accessing health care services identified in their plan of care Denominator: Total # of participants included in the sample

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

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

		Review
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +,-5%
☒ **Other** Specify: PIHP	☐ **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: PIHP	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

OBH reviews and analyzes health and welfare performance measure data to ensure compliance with the sub-assurances. If compliance falls below 100%, OBH reviews remediation actions taken to address issues on an individual-level to ensure appropriate resolution. If compliance falls below the 86% threshold, OBH will require the PIHP to develop a quality improvement plan which must include a root-cause analysis, proposed interventions and associated timelines for addressing non-compliance, and methods and associated timelines for evaluating the success of the plan.

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

OBH draws from multiple sources when determining the need for and methods to accomplish system design changes, including data gathered from member satisfaction surveys, programmatic and administrative evaluations, stakeholder input, claims and quality performance metrics. In addition, OBH monitors waiver performance data to evaluate program performance and to determine the areas that require improvement on both a regional and statewide level. System changes are prioritized based on performance measure results, particularly those impacting member health/welfare or access to care/quality of care, legislative and federal mandates, and stakeholder feedback.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☒ **Other** Specify: PIHP	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The OBH Quality Monitoring Team holds the primary responsibility for monitoring and assessing the effectiveness of system design changes to determine if the desired effect has been achieved. This includes incorporation of feedback from members, stakeholders, providers, and Wraparound Agencies. On a quarterly basis, team members:
-Present and analyze data and information on all delineated performance measures to ensure compliance with state and federal regulations and to identify patterns, trends, and concerns/issues,
-Provide oversight and monitoring of corrective action plans, and
-Develop, oversee, and monitor quality assurance/quality improvement initiatives and activities.
The OBH Quality Monitoring Team meets with the PIHP to discuss any identified issues or concerns.
In addition, BHSF contracts with an EQRO, as required by federal managed care regulations, to evaluate the PIHP's compliance with the quality assurance standards outlined in the contract. Representatives of the OBH Quality Monitoring Team, in conjunction with the External Quality Review Organization (EQRO), also conduct an annual review of the PIHP's compliance with quality and programmatic requirements and standards. A written report of findings is produced by the OBH Director of Quality Management and provided to the PIHP, along with a request for corrective action to address any identified opportunities for improvement.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The OBH Quality Monitoring Team reviews data regarding the PIHP's performance on waiver and quality metrics at least quarterly. The quality improvement strategy is reviewed and updated at least annually, based on the performance measure results, external quality review reports, member/stakeholder feedback, and significant changes to program operations/requirements.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ◉ **Other** *(Please provide a description of the survey tool used):*

State-approved survey tool which assesses overall member satisfaction, access to care, quality of care, and interaction with the PIHP.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

The OBH contract monitor staff meet monthly with the PIHP's administrators allowing for the review of financial reporting and budget items, as needed. Louisiana Medicaid, OBH Fiscal staff, and the Louisiana Department of Insurance (LDI) will each receive a copy of the annual audit. LDH and LDI will review the audit and if it identifies any material issues, it will notify the contract monitor who will ask the PIHP to provide additional information. When a CPA does an audit, one of the items they are required to do is determine if the entity is financially viable for the next fiscal year. If they determine that they are not financially viable, then they are required to issue a going concern opinion. The PIHP by contract is required to have an accounting system with sufficient sophistication to maintain separate fund accountability and is required to have an independent audit of that system completed annually. This requirement is below.

Disclosure of Financial Records and Processes:

The PIHP shall establish and maintain an accounting system in accordance with generally accepted accounting principles (GAAP). The costs properly applicable to Title XIX State Plan services, distinct from Title XIX 1915(c) waiver services, distinct from Title XIX 1915(b)(3) waiver services, shall be accounted for separately and readily ascertainable and auditable. The system shall separately maintain records pertaining to the services and any other costs and expenditures made.

The PIHP and any subcontractors shall make available to the State, its agents, and appropriate federal representatives, any financial records of the PIHP or subcontractors on a quarterly basis. Accounting procedures, policies and records shall be completely open to State and federal audit at any time during the Contract Period and for 10 years thereafter.

The PIHP shall allow the State, CMS, the Office of the Inspector General, the Comptroller General, and their designees to, at any time, inspect and audit any records or documents of the PIHP, and may, at any time inspect the premises, physical facilities, and equipment where Medicaid related activities or work is conducted. The right to audit exists for 10 years from the final date of the contract period or date of completion of any audit, whichever is later in accordance with 42 CFR §438.3(h).

Single Audit Act/Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards (UAR):

This 1915(c) waiver program operates concurrently with the 1915(b) waiver. The §1915(b) waiver financial accountability requirements apply. The state does not make payments directly to waiver providers but instead makes payments to the PIHP for the delivery of waiver services and the PIHP pays providers. Alternative methods are used by LDH to ensure financial accountability, including ensuring that payments are only made to a managed care entity for eligible persons who have been properly enrolled in the waiver.

The PIHP, who manages the 1915(c) waiver services, must contract with and submit an annual independent audit of its internal controls and other financial and performance systems by an external company to ensure financial and operational viability and to ensure contract compliance. The independent audit must comply with the Statement on Standards for Attestation Engagements (SSAE) SSAE No. 16 SOC 2 Type II requirements.

Independent Audit:

The PIHP is required to secure an independent financial audit if they receive more than $750,000 in federal funds (UAR), a condition of the Medicaid provider agreement. The PIHP shall submit an annual independently audited financial report that specifies the PIHP's financial activities within 6 months following the end of the calendar year.

The report, prepared using GAAP or Statutory Accounting Principles as designated by the National Association of Insurance Commissioners (NAIC), must be prepared by an independent Certified Public Accountant selected from a list maintained by the Office of Legislative Auditor on a calendar year basis. The PIHP shall send one copy of the report to the OBH, DFM, and the Office of the Legislative Auditor. The PIHP is responsible for the cost of the audit.

The format and contents of the audit shall be negotiated by the OBH and the PIHP, but shall include at a minimum:

i. Balance Sheet,
ii. Income Statement,
iii. Statement of Cash Flows,
iv. Statement of Retained Earnings,
v. Notes and/or Footnotes to the Financial Statement

In addition to the audited financial statement requirements, OBH will provide a format for additional reporting requirements that will provide information that will provide the following information, that will be submitted no less than annually, but may include quarterly and/or monthly reporting requirements:

1. A separate accounting for all revenues received from each of the reimbursement sources in the Contract (Title XIX, SED waiver, 1915(b)(3), administration, etc.);
2. Title XIX revenue;
3. Third party liability payment made by other third-party payers;
4. A breakdown of the costs of service provision, administrative support functions, plan management including documentation of the PIHPs compliance; and
5. Annually, a separate letter from the independent CPA addressing non-material findings, if any.

In addition to the annual audit, the PIHP shall be required to submit to OBH, a final reconciliation completed by the independent auditing firm that conducted the annual audit. The final reconciliation shall make any required adjustments to estimates included in the audit which must be completed within six months of the end of the Contract year.

CMS Interoperability and Patient Access:

The PIHP shall comply with the CMS Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issues of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers (referred to as the "CMS Interoperability and Patient Access final rule") in accordance with timelines established by CMS and as directed by LDH and/or OBH through the MCE Interoperability Compliance Plan.

Program Integrity:

The post-payment review process is described in Appendix I-2-d. The PIHP conducts post pay reviews to validate that waiver services were in fact provided as billed. The financial integrity review is included in the PIHP's fraud and abuse prevention and detection plan in compliance with managed care regulations at 42 CFR 438 Subpart H including requirements at 438.608(a)(1)(vii) and (5). This includes determining the accuracy of documentation, eligibility, services provided, and units billed. Exact activities include quarterly treatment record reviews. The Wraparound Facilitators are contacting a sample of members on a quarterly basis to verify actual service delivery against the EOB(claims processed).

In accordance with 42 CFR §438.608(a), the PIHP and any subcontractors, to the extent the subcontractor is delegated responsibility for coverage of services and payment of claims, shall have a compliance program that includes administrative and management arrangements or procedures, including a mandatory Fraud, Waste and Abuse Compliance Plan designed to prevent, reduce, detect, correct, and report known or suspected fraud, waste, and abuse in the administration and delivery of services.

In accordance with 42 CFR §438.608(a)(1), the PIHP shall establish a compliance program, and designate a compliance officer and a regulatory compliance committee on the Board of Directors that have the responsibility and authority for carrying out the provisions of the compliance program. The Compliance Officer shall answer directly to the Chief Executive Officer and Board of Directors.

The PIHP shall require all providers and subcontractors take actions, to permit the PIHP, to comply with Program Integrity, Fraud, Waste, and Abuse Prevention requirements. Although all network providers contracts are subject to regulations, the Contractor agrees to require providers comply with regulations and any enforcement actions directly initiated by LDH, including but not limited to termination and restitution. The PIHP, including the Contract Compliance Coordinator and Program Integrity Compliance Officer, shall meet with LDH and the Medicaid Fraud Control Unit (MFCU)to discuss program integrity issues.

The PIHP shall maintain a self-balancing set of records in accordance with Generally Accepted Accounting Procedures. The PHIP agrees to maintain supporting financial information and documents that are adequate to ensure that payment is made in accordance with applicable federal and state requirements, and are sufficient to ensure the accuracy and validity of the PIHP invoices.

The PIHP shall not have restrictions on the right of State and federal governments to conduct inspections and audits as deemed necessary to ensure quality, accuracy, appropriateness or timeliness of services and the reasonableness of their costs. LDH or their designees, may inspect and audit any financial and/or other records of the entity, network providers or

its subcontracts. The Contractor shall provide officials with prompt, reasonable, and adequate access to any records, books, documents, and papers. The Contractor agrees to provide access regardless of where the Contractor maintains such books, records, and supporting documentation.

The PIHP and its employees shall cooperate fully and assist the State and any state or federal agency with the duty of identifying, investigating, or prosecuting suspected fraud, waste or abuse.

The PIHP shall ensure compliance with and/or outline CAPs for any finding of noncompliance based on law, regulation, audit requirement, or generally accepted accounting principles or any other deficiency contained in any audit, review, or inspection conducted. This action shall include the PIHP's delivery to LDH, for approval, a CAP that addresses deficiencies identified in any audit(s), review(s), or inspection(s) shall be submitted within thirty (30) calendar days of the close and final report of the audit(s), review(s), or inspection(s). Upon receipt and review of the submitted CAP, LDH will notify the PIHP that its CAPs are accepted, rejected, or require modification of any portion found to be unacceptable.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
FA1: The proportion of claims paid by the PIHP for CSoC waiver services that have been paid in accordance with the approved rate methodology. Numerator = Number of waiver claims paid for services that have been paid in accordance with the approved rate methodology, Denominator = Total number of paid waiver claims.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Report from PIHP/UM to OBH

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:* *PIHP*	☒ ***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:* *PIHP*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other***

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
FA2: Number and percent of capitation payments to the PIHP that are made in accordance with the CMS approved actuarially sound rate methodology. Numerator = capitation payments made to PIHP at the approved rate through the CMS certified MMIS; Denominator = all capitation payments made to the PIHP through the CMS certified MMIS.

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:
MMIS Data

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:*

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

OBH reviews and analyzes aggregated financial accountability performance measure data to ensure compliance with the sub-assurance. If compliance falls below 100% for performance measure FA2, OBH will work with the SMA and the MMIS contractor to
determine the cause of the problem and remediate each occurrence. If compliance falls below 86% for performance measure FA1, OBH will require the PIHP to complete a quality improvement plan which includes a root-cause analysis, proposed interventions and associated timelines to improve performance, and methods and associated timelines for evaluating the success of the plan.

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:* *PIHP*	☐ ***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 Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

Please reference the concurrent 1915(b) Healthy Louisiana and Coordinated System of Care (CSoC) Waiver LA.0004 application and associated materials.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Billings for waiver services are submitted directly by waiver provider(s) to the PIHP. The PIHP is required per contract to submit encounters to the State MMIS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

When an individual has been determined to be eligible for the waiver, the PIHP sends notification to LDH or its designee.

An electronic medical record or plan of care (POC) is developed for all participants served through the waiver. All waiver services on the plan of care are prior-authorized by the PIHP. Communication between the Wraparound Agency and the PIHP will occur to ensure that the plan of care is received, reviewed, and approvals are processed in a timely manner as detailed below.

When a waiver service claim is submitted to the PIHP, the PIHP's system electronically checks the plan of care database and the eligibility roster to ensure the child/youth is waiver eligible for the dates of services included on the claim. In addition, the PIHP's system electronically checks the provider file to assure the provider is enrolled with the PIHP and is approved to receive Medicaid waiver payment for the date of services.

The PIHP conducts post pay reviews to validate waiver services were in fact provided as billed. This financial integrity review is included in the PIHP's fraud and abuse prevention and detection plan in compliance with managed care regulations at 42 CFR 438 Subpart H including requirements at 438.608(a)(1)(vii) and (5). This includes determining the accuracy of documentation, eligibility, services provided, and units billed. The Wraparound Facilitators are contacting a sample of members on a quarterly basis to verify actual service delivery against the EOB (claims processed).

Providers must ensure that the services are provided in accordance with the approved plan of care, maintain adequate supporting documentation of services provided and complete data entry into the PIHP's electronic health record and database that captures services provided.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ○ ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ◉ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

The PIHP contract for children/youth services utilizes a risk-based payment methodology and requires the PIHP to obtain an independent audit that reconciles all payments, including waiver payments, with the invoices and encounter data. Louisiana has established pricing based on similar services. Room and board costs are not included in the per member per months payments for the Title XIX members.
The PIHP payments are as outlined in the contract. The payment may be adjusted based on applicable program changes, trend, etc. after each reconciliation. The final payment for 1915(c) services will not exceed what would have been paid had the same services been provided under the 1915(c) SED waiver. The OBH fiscal staff closely monitors this process for accuracy.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☒ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

No waiver services are excluded from the PIHP

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS.

Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

State and local behavioral health clinics may enroll as a qualified provider to provide services under the waiver if they meet waiver provider qualification requirements.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for*

expenditures made by states for services under the approved waiver. Select one:

- ○ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ◉ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

The PIHP is paid on a full risk basis for services provided to children/youth. The federal share of any funds returned to the state as a result of the reconciliation are returned to the federal government.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the***

delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

◉ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer

(IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The full risk payments to the PIHPs are based on expenditures for services in the waiver. PMPM payment rates are based on the cost of providing the service exclusive of room and board. Other funding sources may be used by the State and local governments to pay for room and board in licensed residential facilities.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing *(1 of 5)*

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Hospital, Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	3065.38	4458.00	7523.38	6638.00	9503.00	16141.00	8617.62
2	3231.08	4592.00	7823.08	6837.00	9788.00	16625.00	8801.92
3	3428.95	4730.00	8158.95	7043.00	10081.00	17124.00	8965.05
4	3624.21	4872.00	8496.21	7254.00	10384.00	17638.00	9141.79
5	3824.66	5018.00	8842.66	7471.00	10695.00	18166.00	9323.34

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates *(1 of 9)*

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Hospital	Nursing Facility
Year 1	5557	5555	2
Year 2	5557	5555	2
Year 3	5557	5555	2
Year 4	5557	5555	2
Year 5	5557	5555	2

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates *(2 of 9)*

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The latest 372 report reported that the ALOS estimate was 197 days for this waiver.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

The state has updated the factor D to reflect the actual July 2018 - June 2019 372 data and to be consistent with CY 2019 encounter data. From the 372 report from July 2018 - June 2019, the waiver served 3,212 users and waiver services cost $7,646,592. D was $2,381.

Based on a review of actual reimbursement from the contracted managed care organization, as seen in the CY 2019 encounter data, the short-term respite unit cost was adjusted from the State's fee schedule. Based on a review of historical expenditures of waiver services and continued ramp-up, we project the total number of waiver participants will increase, utilization of most waiver services will increase, and the total cost will increase between SFY19 and SFY23, the new Waiver Year 1. After adjusting for these factors to arrive at the Waiver Year 1 Factor D ($3,065), we apply similar adjustments to calculate Factor D for the subsequent waiver years. We project that utilization for Independent Living/Skill Building grows by 0.5% annually, Parent Support and Training - Individual increases by 1% annually, Short-Term Respite increases by 1.25% annually, and Youth Support and Training - Individual increases by 2% annually. We project that the total cost of Independent Living/Skills Building increases by 4% annually, Parent Support and Training - Group, Short-Term Respite, Youth Support and Training - Group, and Youth Support and Training - Individual increase by 7% annually, and Parent Support and Training - Individual increases by 5% annually to calculate Factor D for the remaining waiver years."

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The State’s D’ from the July 2018 - June 2019 372 report was $3,961. A trend rate of 3.0% based on review of CPI-U trends for Medical Care was utilized to annually inflate the D’ using the formula: [Historical D’ x (1 + trend %) ^ (month/12)]. The Waiver Year 1 D’ is $4,458 because four years of trend were utilized to inflate from SFY19 to SFY23, Waiver Year 1 of the renewal. We project the Factor D' for the following waiver years using the same 3.0% annual inflation estimate.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The State’s G from the July 2018 - June 2019 372 report was $5,898. The State’s actual experience data only includes information from the hospital level of care. No Medicare part D drug costs are included. A trend rate of 3.0% based on review of the CPI-U trends for Nursing Homes and Adult Day Services was utilized to annually inflate the G using the formula: [Historical G x (1 + trend %) ^ (month/12)]. The Waiver Year 1 G is $6,638 because 4 years of trend were utilized to inflate from SFY19 to SFY23, Waiver Year 1 of the renewal. We project the Factor G for the following waiver years using the same 3.0% annual inflation estimate.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The State's G' from the July 2018 - June 2019 372 report was $8,443. The State's data only includes information from the hospital level of care. No Medicare part D drug costs are included. A trend rate of 3.0% based on review of CPI-U trends from Medical Care was utilized to annually inflate the G' using the formula: [Historical G' x (1 + trend %) ^ (month/12)]. The Waiver Year 1 G' is $9,503 because 4 years of trend were utilized to inflate from SFY19 to SFY23, Waiver Year 1 of the renewal. We project the Factor G' for the following waiver years using the same 3.0% annual inflation estimate.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Independent Living/Skills Building	
Parent Support and Training	
Short-Term Respite	
Youth Support and Training	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	*Capi-tation*	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Independent Living/Skills Building Total:							***1933035.00***
Independent Living/Skil	☒	*15 minute*	*575*	*431.00*	*7.80*	***1933035.00***	
Parent Support and Training Total:							***7597103.24***
Group	☒	*15 minute*	*29*	*10.00*	*3.23*	***936.70***	

GRAND TOTAL:		***17034304.84***
Total: Services included in capitation:		*17034304.84*
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:		***5557***
Factor D (Divide total by number of participants):		***3065.38***
Services included in capitation:		*3065.38*
Services not included in capitation:		
Average Length of Stay on the Waiver:	*197*	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual	☒	15 minute	4391	134.00	12.91	7596166.54	
Short-Term Respite Total:							1988454.00
Short-Term Respite	☒	15 minute	962	318.00	6.50	1988454.00	
Youth Support and Training Total:							5515712.60
Group	☒	15 minute	69	13.00	3.23	2897.31	
Individual	☒	15 minute	2557	167.00	12.91	5512815.29	

GRAND TOTAL:	17034304.84
Total: Services included in capitation:	17034304.84
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	5557
Factor D (Divide total by number of participants):	3065.38
Services included in capitation:	3065.38
Services not included in capitation:	
Average Length of Stay on the Waiver:	197

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Living/Skills Building Total:							2009716.80
Independent Living/Skills Building	☒	15 minute	602	428.00	7.80	2009716.80	
Parent							7923716.63

GRAND TOTAL:	17955100.70
Total: Services included in capitation:	17955100.70
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	5557
Factor D (Divide total by number of participants):	3231.08
Services included in capitation:	3231.08
Services not included in capitation:	
Average Length of Stay on the Waiver:	197

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support and Training Total:							
Group	☒	15 minute	29	11.00	3.23	**1030.37**	
Individual	☒	15 minute	4447	138.00	12.91	**7922686.26**	
Short-Term Respite Total:							**2126436.00**
Short-Term Respite	☒	15 minute	1032	317.00	6.50	**2126436.00**	
Youth Support and Training Total:							**5895231.27**
Group	☒	15 minute	69	14.00	3.23	**3120.18**	
Individual	☒	15 minute	2669	171.00	12.91	**5892111.09**	

GRAND TOTAL:	**17955100.70**
Total: Services included in capitation:	17955100.70
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**5557**
Factor D (Divide total by number of participants):	**3231.08**
Services included in capitation:	3231.08
Services not included in capitation:	
Average Length of Stay on the Waiver:	197

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent							**2088450.00**

GRAND TOTAL:	**19054686.97**
Total: Services included in capitation:	19054686.97
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**5557**
Factor D (Divide total by number of participants):	**3428.95**
Services included in capitation:	3428.95
Services not included in capitation:	
Average Length of Stay on the Waiver:	197

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Living/Skills Building Total:							
Independent Living/Skills Building	☒	15 minute	630	425.00	7.80	**2088450.00**	
Parent Support and Training Total:							**8370522.12**
Group	☒	15 minute	29	12.00	3.23	**1124.04**	
Individual	☒	15 minute	4502	144.00	12.91	**8369398.08**	
Short-Term Respite Total:							**2275767.00**
Short-Term Respite	☒	15 minute	1101	318.00	6.50	**2275767.00**	
Youth Support and Training Total:							**6319947.85**
Group	☒	15 minute	69	15.00	3.23	**3343.05**	
Individual	☒	15 minute	2780	176.00	12.91	**6316604.80**	

GRAND TOTAL:	**19054686.97**
Total: Services included in capitation:	19054686.97
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**5557**
Factor D (Divide total by number of participants):	**3428.95**
Services included in capitation:	3428.95
Services not included in capitation:	
Average Length of Stay on the Waiver:	197

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Living/Skills Building Total:							**2176137.60**
Independent Living/Skills Building	☒	15 minute	658	424.00	7.80	**2176137.60**	
Parent Support and Training Total:							**8768940.93**
Group	☒	15 minute	29	13.00	3.23	**1217.71**	
Individual	☒	15 minute	4558	149.00	12.91	**8767723.22**	
Short-Term Respite Total:							**2435680.00**
Short-Term Respite	☒	15 minute	1171	320.00	6.50	**2435680.00**	
Youth Support and Training Total:							**6758994.53**
Group	☒	15 minute	69	16.00	3.23	**3565.92**	
Individual	☒	15 minute	2891	181.00	12.91	**6755428.61**	

GRAND TOTAL:	**20139753.06**
Total: Services included in capitation:	20139753.06
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**5557**
Factor D (Divide total by number of participants):	**3624.21**
Services included in capitation:	3624.21
Services not included in capitation:	
Average Length of Stay on the Waiver:	197

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Living/Skills Building Total:							**2263388.40**
Independent Living/Skills Building	☒	15 minute	686	423.00	7.80	**2263388.40**	
Parent Support and Training Total:							**9174495.67**
Group	☒	15 minute	29	13.00	3.23	**1217.71**	
Individual	☒	15 minute	4614	154.00	12.91	**9173277.96**	
Short-Term Respite Total:							**2603380.00**
Short-Term Respite	☒	15 minute	1240	323.00	6.50	**2603380.00**	
Youth Support and Training Total:							**7212371.31**
Group	☒	15 minute	69	17.00	3.23	**3788.79**	
Individual	☒	15 minute	3002	186.00	12.91	**7208582.52**	

GRAND TOTAL:		**21253635.38**
Total: Services included in capitation:		21253635.38
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:		**5557**
Factor D (Divide total by number of participants):		**3824.66**
Services included in capitation:		3824.66
Services not included in capitation:		
Average Length of Stay on the Waiver:	197	