

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

Request for 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:

Significant changes to the renewal application include:

- Modify the age limit in order to target services to the most high-need children/youth and to align with the EPSDT program. Current members who are between the ages of 0-5 and 20-21 will be allowed to continue receiving CSoc services as long as they continue to meet the level of care requirements.

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.R01.00

Draft ID: LA.029.01.00

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

Regular Waiver

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

07/01/17

Approved Effective Date: 07/01/17

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 in 42 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 Bayou Health 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 Eligibility 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 divert nursing facility and psychiatric hospitalization placement for children and youth through the provision of intensive home and community-based supportive services. 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, an agency under the Department of Health and Hospitals. Waiver services are provided by the PIHP through a contract with the Bureau of Health Services Financing (Medicaid).

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. Statewide. 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:

- As specified in Appendix C, adequate standards for all types of providers that provide services under this waiver;
- 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:
Initially, nine town hall meetings were held throughout the State to announce the program and gather input from the public from February 17 through March 3, 2011.

In addition, a news <https://wms-mmdl.cdsvdc.com/WMS/faces/protected/35/assurances.jsp#aper> notice in the State's eight major daily newspapers, as well as the Louisiana Register, was placed on March 11, 2011 to notify the public of the availability of proposed State Plan Amendments including reimbursement changes, proposed 1915(c) and 1915(b) waivers, as well as the public meeting scheduled on March 28, 2011.

The State published a notice in all the major newspapers in the State on July 18, 2014 to inform the public of the significant changes proposed through this waiver amendment. The State also notified the public of the State's plan to

comply with the home and community-based setting regulations by direct email to stakeholders on September 30, 2014 and April 1, 2015, and by publishing a notice in all major newspapers in the State on October 10, 2014. The State also presented information about the home and community-based setting regulations and the State's plan to comply with said regulations at seven stakeholder meetings beginning September 29, 2014; the last three meetings were held via webinar during the month of February 2015.

The public notice was provided via newspaper publication in the 8 major daily newspapers of the State on 10-30-15 and via a blast email to stakeholders on 9-22-15. Interested persons could submit comments and feedback by mail or email.

LDH issued a public notice on October 28, 2016 to announce its intent to submit a renewal. Public Notice for the changes in the waiver renewal were accomplished through the rule making process that requires publication of a summary of proposed changes in the major newspapers of the state and the Louisiana Register. LDH received no comments regarding the waiver renewal from the public.

For this renewal, all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit this Medicaid waiver renewal request to CMS. This notice was made October 28, 2016, and a copy of the applicable notice is available through the Medicaid Agency. LDH received no comments regarding the waiver renewal from Tribal Governments.

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:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Louisiana

Zip:

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:**

Stubbs

First Name:

Karen

Title:

Deputy Assistant Secretary

Agency:

Office of Behavioral Health

Address:

628 N. 4th Street

Address 2:**City:**

Baton Rouge

State:

Louisiana

Zip:

70802-4049

Phone:(225) 342-1435 Ext: TTY**Fax:**

(225) 342-5066

E-mail:

Karen.Stubbs@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:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Louisiana**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

Crisis Stabilization was removed as a waiver service and added to the state plan. During the transition all members enrolled in this waiver continued to receive crisis stabilization. The transition plan was for members to continue to receive this service through the waiver managed by the PHIP until the state plan was approved. Upon approval of the state plan amendment to add crisis stabilization, members continued to receive the service from the same providers with no interruption. The PHIP continued to manage crisis stabilization as a state plan service. All waiver members can continue to access this service through the state plan.

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

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

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

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

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

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

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

Updates to the STP since submission include:

Stakeholder Engagement

Distributed letters to providers describing the transition, criteria for HCB setting, deadlines for compliance, and availability of TA - 4/1/15

Drafted self-assessment for public review - 3/31/15

Posted on website for public notice - 4/1/15

Circulated to stakeholders - 5/1/15

Drafted participant survey for public review - 4/30/15

Posted on website for public notice - 4/30/15

Circulated to stakeholders - 6/1/15

No comments were received for the period 3/18/15 - 6/30/15

Distribute participant/member survey - 3/1/16

Conduct site visits - 3/1/16

Review licensure, certification, policy, procedures, and provider qualifications - 7/22/16

Public comment on revised transition plan - 9/14/16 - 10/14/16

No comments were received for the period 9/14/16 - 10/14/16

The Louisiana Department of Health submitted a transition plan to CMS that explains how the State will bring its HCBS waivers into compliance with the new regulations. This plan was drafted through a collaborative effort by the Office of Aging and Adult Services, the Office of Behavioral Health, the Office for Citizens with Developmental Disabilities, and Medicaid. After the CMS review in the late summer, Louisiana amended the Statewide Transition Plan (STP) to include robust information about the systemic assessment review of state statutes, waivers, policy and procedures, and other documentation. Minor adjustments were made in the areas of work plans and other activities.

A) Stakeholder Engagement:

OBH initiated the development of a public comment phase. To that end, OBH created a website on September 30, 2014 and published information about the new Settings Rule and the plan to comply. Public notice appeared in major newspapers on October 10, 2014. Comments on this information were due on November 10, 2014. All potential stakeholders, including consumers, providers, family members, state associations, advocacy organizations and self-advocates were identified on October 31, 2014.

Several forums were held to present information about the HCB settings rule: 1) September 29, 2014: Statewide Coordinating Council; 2) October 22, 2014: CSoC Governance Board meeting; 3) October 23, 2014: Affinity call with CSoC Wraparound Facilitators; 4) November 3, 2014: Louisiana Behavioral Health Advisory Committee. April 1, 2015 through May 1, 2015 letters were distributed to providers and provider associations describing the transition, criteria for compliance with the HCB setting rule, deadlines for compliance, and availability of technical assistance. A spreadsheet was created to track comments.

Public comment was taken from September 30, 2014 through November 10, 2014. The public was invited to submit comments through an email address obh-hcbs@la.gov. The Office of Behavioral Health presented information regarding the home and community-based setting rule and OBH's plan to comply with the rule at four stakeholder forums, which were held beginning September 29, 2014.

Comments received in-person have been paraphrased based on notes taken by department staff present at the stakeholder forum. In addition, the Department received a letter from the Advocacy Center and OBH's response.

1. Will we be able to attend the meeting on 11/3/14 and express any concerns that we might have?

Department Response: Yes

2. Will there be an opportunity for conference call at the meeting on 11/3/14 or would we need to attend in person?

Department Response: There isn't a conference call capability for the meeting on 11/3/14.

3. Would the rule apply to sheltered workshops?

Department Response: Yes

4. Would this apply to drop-in facilities for homeless people?

Department Response: We don't believe so. It's our understanding that short-term services meant to divert the person from institutional care would be presumed to be home and community-based.

5. Can we be notified of public forums?

Department Response: Yes, we will notify stakeholders of future meetings through direct email.

6. Who is responsible for monitoring providers' compliance with the transition plan?

Department Response: OBH will be responsible for monitoring providers' compliance with the rule and transition plan.

7. How does OBH plan to identify issues?

Department Response: OBH will conduct a Participant Experience Survey to assess participants' HCBS experience and a Provider Self-Assessment beginning in March 2015 to determine if provider settings comport with the home and community-based rule. Based on the results, OBH will conduct onsite visits to a sample of residential and non-residential settings to ensure compliance with the HCB setting regulation. OBH will assist providers in remediating any areas which are out of compliance with the rule. For settings that are presumed to be an institution, OBH will assess whether the setting has the characteristics of a HCBS; if OBH believes the setting has HCBS characteristics, OBH will provide evidence to CMS who will make the final decision as to whether the setting is HCBS. In addition, OBH will monitor whether settings continue to comply with the regulations through provider monitoring and participant feedback.

8. Has OBH reached out to providers?

Department Response: Yes, OBH has notified providers of the home and community-based rule through direct email. Providers were also informed that they could find more information about OBH's plan to comply with the rule on our website.

In addition the revised STP was made available to the public on September 14, 2016, in both an electronic version posted on the LDH program offices websites and by hardcopy which was provided upon request. Comments were due October 14, 2016. No comments were received.

B) Assessment and Review:

A provider self-assessment instrument was originally drafted on March 21, 2015 and posted to the website the next day for public comment. No comments were received. On May 1, 2015, the self-assessment was circulated to stakeholders and posted on the website and an email requesting feedback was sent to stakeholders. The tool was later revised based on CMS' exploratory questions document. Following a 30 day comment period, OBH required the CSoc Contractor to collect information from all HCBS provider applicants and providers through the credentialing/recredentialing process to determine compliance with the HCB setting rule. Initial providers will be expected to be fully in compliance with the HCB setting rule prior to rendering waiver services. Current providers who are not fully in compliance will be required to submit a corrective action plan.

In addition, OBH will ensure members reside in HCB settings through a participant survey, which is conducted by Wraparound Facilitators during their quarterly face-to-face visits.

The assessment process began March 2016. Analysis of findings began March 2016 and is expected to conclude by April 30, 2017. The findings will be posted by May 30, 2017 with a final report submitted to CMS by June 30, 2017.

C) Remediation:

Ensuring Providers are Compliant

Staff will determine if: 1) the setting is in compliance; 2) the setting will be in compliance with additional modifications; or 3) the setting is out of compliance. Site visits will also validate compliance. Providers who are not in compliance with the HCB Setting Rule will be notified in writing and required to come into compliance in order to continue providing CSoc services. Each provider will have the opportunity to provide the State additional information to show they are in compliance. Providers who are not in compliance may request technical assistance from the State but will be required to submit and implement a State approved corrective action plan. The CSoc Contractor will conduct an on-site reviews to evaluate the validity of remediation compliance. An appeal process, to be developed, will allow the provider to dispute the HCB Setting's compliance. A disenrollment process of non-compliant providers will be developed and consist of: 1) provider disenrollment as a CSoc provider 2) a transition plan for participants; and 3) an appeal mechanism for participants and providers. Implementation of a transition plan will be developed for those needing to transfer to an appropriate HCB Setting. Individuals will be given timely notice and a choice of alternative providers. Transition of each individual will be tracked to ensure successful placement and continuity of services.

Ensuring Quality

All certifications, licensing, rules, policy and procedures and other documents have been reviewed to ensure compliance with the HCB Setting Rule. The provider enrollment process, provider qualifications, and service definitions are in line with the Setting Rule. All staff associated with the above listed functions will be trained on the new regulations and the Louisiana Statewide Transition Plan. Changes to enhance support of the Settings Rule will continue to be considered and adopted. Louisiana assesses provider compliance through reports, interviews and on-site inspections that will gather information from providers and individuals receiving services. Participant surveys are conducted to obtain individual's perception of the Settings Rule.

Progress on completion of this Statewide Transition Plan will be monitored at least every three months and will include public posting on the status of the Plan to facilitate public input. Stakeholder engagement and sharing public information will continue through the implementation of the Plan, with the following benchmarks appearing on the website: 1) final copies of the residential and non-residential assessment documents; 2) final copy of the participant survey; and 3) a copy of the Master Plan, updated as needed. Each Office will issue a final report to CMS in March, 2019.

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

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 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. To ensure compliance with federal regulations governing specialized behavioral health state plan and waiver services, BHSF created the Medicaid Behavioral Health Services (MBHS) Section to oversee the administration of all Louisiana Medicaid state plan and waiver programs. Monitoring is completed under the direction of the MBHS Section Chief. The MBHS Section, through performance measures listed in the Quality Improvement Strategy (QIS) and systems described in Appendix H, ensures that OBH performs its assigned waiver operational functions in accordance with this document.

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. LHH 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 MBHS Section
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 receiving services, 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, DHH’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 MBHS 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 MBHS 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 MBHS 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 - To ensure compliance with federal regulations governing this waiver, BHSF created the Medicaid Behavioral Health Services (MBHS) Section. Monitoring is completed under the direction of the MBHS Section Chief. The MBHS Section, through performance measures listed in the Quality Improvement Strategy (QIS), and systems described in Appendix H, ensures that OBH performs its assigned waiver operational functions including participant health and welfare assurances in accordance with this document. OBH submits performance measure data, analysis and remediation actions to MBHS 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.:*

Wraparound Agencies:

Local Wraparound Agencies (WAA) will be the locus of treatment planning for the provision of all waiver services. Wraparound Agencies are the care management agencies for the day-to-day operations of the waiver. The Wraparound Agencies will contract through the PIHP.

This contractor will complete all initial Level of Care determinations and re-determinations utilizing the Child and Adolescent Needs and Strengths (CANS) and Individualized Behavioral Health Assessment (IBHA) tools. Once an individual is receiving waiver services, the contractor will complete another assessment at least every 6 months or when notified by the PIHP of a change in status (improvement or decline) that might warrant a change in the individual's level of services.

OBH conducts monitoring by reviewing the aggregated data reports detailing the WAA contracted duties and specific performance measures submitted on at least a monthly basis to OBH. Reports include administrative activities (staffing rates and staff training), monthly call volumes, screening data, CSoc admission and discharge data, improvements to information technology used to support contract functions. When corrective action is required, a Corrective Action Plan (CAP) is requested by OBH and follow up will be conducted to evaluate the effectiveness of the CAP. Monitoring also includes observation of WAA calls and processes and results in training, policy clarification, and other technical assistance and remediation as indicated. OBH will utilize a record review audit tool to examine a representative random sample that is submitted by the PIHP to determine whether the eligibility screening process was conducted and applied appropriately. Retrospective review of Level of Care (LOC) assessments will occur through a monitoring review process performed by OBH staff. The monitoring process is described in the Level of Care Quality Improvement section.

Prepaid Inpatient Health Plan:

The Prepaid Inpatient Health Plan (PIHP) must assure that the policies and procedures for the waiver are followed. The PIHP is responsible for the health, safety and welfare of child/youths receiving services, for assuring integrity and improvement of the provision of services and supports with the Wraparound Agency. The PIHP responsibilities are as follows:

1. Report to the OBH and serve as the single point of entry for HCBS evaluations and contact with the Medicaid eligibility staff.
2. Provide information to waiver participants about their rights and protections.
3. Assure family/participant awareness and choice for all available waiver services and responsibilities, including the right to change providers.
4. Resolve issues related to participants' health and safety and service delivery that are unresolved
5. Contract with an adequate number of network service providers and pay claims.
6. Maintain service provider list, recruit providers to address unmet needs, provide training and technical assistance to providers contracted to provide services.

- 7. Provide utilization management through prior authorization and review of paid claims data with follow-up as necessary.
 - 8. Quality management activities including collecting trending and reporting to OBH required data such as access to services, network sufficiency, abuse and neglect incidences, waiver enrollment, and waiver performance measures
 - 9. Conduct grievance and appeal activities and provide data to DHH. Provide or arrange for 24/7/365 crisis response system.
 - 11. Conduct ongoing monitoring of contracted providers based on a standardized monitoring protocol and scheduled based on an approved performance measures in waiver.
 - 12. Oversee and provide follow-up of to ensure implementation of plans of correction.
- 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 (OBH), and the Louisiana Bureau of Health Services Financing (BHSF), are responsible for assessing the performance of the operational and administrative functioning of the PIHP.

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:

PIHP:

Comprehensive monitoring of the PIHP will be compliant with 42 CFR 438.66 and is described in detail in the concurrent 1915(b) application. Specific to delegated waiver operations, the state will assess performance as follows. BHSF and OBH will perform on-going monitoring of the PIHP's activities and adherence to the terms of the contract through review of reports and deliverables, compliance reviews, validation of performance measures and performance improvement projects, and routine meetings to discuss waiver operations.

LDH will require the PIHP to develop and implement service authorization policies and procedures consistent with 42 CFR §438.210, 1915(b) and 1915(c) waivers, and state laws and regulations for initial and continuing authorization of services that include, but are not limited to, the following:

- Written policies and procedures to address provider failure to perform tasks necessary for timely authorization of services;
- Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;
- Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease;
- Provide a mechanism in which a member or provider may submit, whether oral or in writing, a service authorization request for the provision of services. This process shall be included in its member manual and incorporated in the grievance procedures;
- The PIHP's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers; and
- The PIHP's service authorization system shall have capacity to electronically store and report the time and date all service authorization requests are received, decisions made by the PIHP regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.

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	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

A.a.i.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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample

		Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

AA1 Numerator: Number of participants whose plan of care shows evidence that their setting meets HCBS requirements and in a provider-owned or controlled setting the additional requirements are met
Denominator: Total number of participants

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

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

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: PIHP	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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.

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v

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
 OBH oversees the PIHP’s monitoring and remediation process through regular review of data reports, compliance reviews, and bi-monthly meetings with PIHP staff regarding waiver operations. OBH directs the PIHP to take corrective action in the event that performance is below the established threshold or there is non-compliance with contractual requirements. OBH reviews the corrective action plan to determine if it is acceptable and monitors the corrective action plan until all interventions have been taken and performance improves.

Medicaid as the administrating agency fully participated in all quality oversight and data validation activities as stated above conducted by OBH, the operating agency.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; text-align: right; padding-right: 5px;"> ^ v </div>

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.

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v

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
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input checked="" type="checkbox"/> Mental Illness					
	<input checked="" type="checkbox"/>	Mental Illness	18	20	
	<input checked="" type="checkbox"/>	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 15, and continuing until the member approaches the age of 21 years, a continuum of services will be identified on the Plan of Care through the Child and Family Team process to aid in the transition process. The Wraparound Facilitator will identify links and supports to access to services identified on the Plan of Care to enable the youth to achieve a successful transition. Coordination between the OBH children and youth programs and OBH adult programs will aid in the transition.

The Wraparound Facilitator will facilitate the development and implementation of the transition plan in the Plan of Care through the Child and Family team process for each member as he/she approaches age 21. One strategy in the transition planning process will be a referral to the child's Healthy Louisiana plan to determine eligibility for adult community-based services and mental health supports. If the member meets the applicable criteria for another waiver, a referral will be made to aid transition to that program supported by OBH that is determined to best meet the youth's needs.

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 (POC) is developed for the child 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 onto 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 family or other members of the Child and Family Team may convene a Child and Family Team (CFT) meeting at any time there is an increased need for service by the child/youth. If the CFT determines that 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 it is determined through the CFT process that during the 90 day time period that the child/youth has an extended need for increased intensity of services, the child will be re-assessed by a CANS Certified LMHP. The results will be reviewed by PIHP staff selected to be on the independent review team. The child/youth will be 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	4600
Year 2	

Waiver Year	Unduplicated Number of Participants
	4600
Year 3	4600
Year 4	4600
Year 5	4600

- 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	2400
Year 2	2400
Year 3	2400
Year 4	2400
Year 5	2400

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:

The OBH does not have a waiting list for the CSoC waiver. A waiting list is not anticipated to be put in place. 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)

Waiver Phase-In/Phase-Out Schedule

Based on Waiver Proposed Effective Date: 07/01/17

a. The waiver is being (select one):

- Phased-in
- Phased-out

b. Phase-In/Phase-Out Time Schedule. Complete the following table:

Beginning (base) number of Participants:

Phase-In/Phase-Out Schedule

Waiver Year 1			
Unduplicated Number of Participants: 4600			
Month	Base Number of Participants	Change	Participant Limit
Jul	1200	0	1200
Aug	1200	0	1200
Sep	1200	0	1200
Oct	1200	0	1200
Nov	1200	0	1200
Dec	1200	0	1200
Jan	1200	0	1200
Feb	1200	0	1200
Mar	1200	0	1200
Apr	1200	0	1200
May	1200	0	1200
Jun	1200	0	1200

Waiver Year 2			
Unduplicated Number of Participants: 4600			
Month	Base Number of Participants	Change	Participant Limit
Jul	1200	0	1200
Aug	1200	0	1200
Sep	1200	0	1200
Oct	1200	0	1200
Nov	1200	0	1200
Dec	1200	0	1200
Jan	1200	0	1200
Feb	1200	0	1200
Mar	1200	0	1200
Apr	1200	0	1200
May	1200	0	1200
Jun	1200	0	1200

Waiver Year 3
Unduplicated Number of Participants: 4600

Waiver Year 4
Unduplicated Number of Participants: 4600

Phase-In/Phase-Out Schedule

Month	Base Number of Participants	Change	Participant Limit
Jul	1200	480	1680
Aug	1680	240	1920
Sep	1920	240	2160
Oct	2160	240	2400
Nov	2400	0	2400
Dec	2400	0	2400
Jan	2400	0	2400
Feb	2400	0	2400
Mar	2400	0	2400
Apr	2400	0	2400
May	2400	0	2400
Jun	2400	0	2400

Month	Base Number of Participants	Change	Participant Limit
Jul	2400	0	2400
Aug	2400	0	2400
Sep	2400	0	2400
Oct	2400	0	2400
Nov	2400	0	2400
Dec	2400	0	2400
Jan	2400	0	2400
Feb	2400	0	2400
Mar	2400	0	2400
Apr	2400	0	2400
May	2400	0	2400
Jun	2400	0	2400

Waiver Year 5
Unduplicated Number of Participants: 4600

Month	Base Number of Participants	Change	Participant Limit
Jul	2400	0	2400
Aug	2400	0	2400
Sep	2400	0	2400
Oct	2400	0	2400
Nov	2400	0	2400
Dec	2400	0	2400
Jan	2400	0	2400
Feb	2400	0	2400
Mar	2400	0	2400
Apr	2400	0	2400
May	2400	0	2400
Jun	2400	0	2400

c. Waiver Years Subject to Phase-In/Phase-Out Schedule

Year One	Year Two	Year Three	Year Four	Year Five
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

d. Phase-In/Phase-Out Time Period

	Month	Waiver Year
Waiver Year: First Calendar Month	Jul	
Phase-in/Phase-out begins	Jul	3
Phase-in/Phase-out ends	Oct	3

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a (*select one*):

- §1634 State
 SSI Criteria State
 209(b) State

2. **Miller Trust State.**

Indicate whether the State is a Miller Trust State (*select one*):

- No
 Yes

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

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

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

Select one:

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

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
 Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
 Working individuals with disabilities who buy into Medicaid (TWWIA 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 spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- Aged and disabled individuals who have income at:**

Select one:

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

- Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- The following standard included under the State plan**

Select one:

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

(*select one*):

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

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

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the State Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

Not Applicable (see instructions)

SSI standard

Optional State supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

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

Specify:

- Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly

income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- The following standard included under the State plan**

Select one:

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

(select one):

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

Specify the percentage:

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

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the State Plan**

Specify:

- The following dollar amount**

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

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

Specify:

Other

Specify:

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

Not Applicable

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

Specify:

Specify the amount of the allowance (select one):

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The following dollar amount:**

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

- AFDC need standard**
- Medically needy income standard**
- The following dollar amount:**

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

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

Specify percentage:

- The following dollar amount:**

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

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

Specify formula:

- Other**

Specify:

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

Select one:

- Allowance is the same**
 Allowance is different.

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

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

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 an entity under contract with the Medicaid agency.

Specify the entity:

- Other

Specify:

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

Medical, psychiatric, and psychosocial evaluations to assess medical eligibility for hospital level of care are performed by LMHPs practicing under their scope of practice as permitted under State law and physicians and are forwarded to the PIHP for an independent review. The PIHP has identified staff that serves on the independent review team that are responsible for determining whether the child or youth meets medical eligibility for Hospital or Nursing Facility Level of Care subject. All determinations are subject to final review by the PIHP.

Physician (MD or DO) or Other Licensed mental health practitioner (LMHP) licensed to practice independently:

- Medical Psychologists
- Licensed Psychologists
- Licensed Clinical Social Workers (LCSWs)
- Licensed Professional Counselors (LPCs)
- Licensed Marriage and Family Therapists (LMFTs)
- Licensed Addiction Counselors (LACs)
- Advanced Practice Registered Nurses (must be a nurse practitioner specialist in Adult Psychiatric & Mental Health, and Family Psychiatric & Mental Health or a Certified Nurse Specialists in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health, and Child-Adolescent Mental Health and may practice to the extent that services are within the APRN's scope of practice)

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 initial CANS is completed by a CANS certified LMHP when they score positive on the Brief CANS and are referred for services. The initial CANS must be completed within 30 days of the referral and is used to develop the initial Plan of Care. A CANS is also completed every 180 days that the child/youth is enrolled in CSoC and a final CANS is completed at the time the child/youth is discharged from CSoC.

A CANS is also completed at any time during the child/youth's enrollment in CSoC if it is determined through the CFT process that the child/youth has a significant change in risk factors, an extended need for increased services has been identified, or a decision regarding changes in level of care is required.

The CANS Comprehensive Multisystem Assessment is completed based on a face-to-face interview with the child and parent(s) and additional supporting information. In certain circumstances (such as when the youth being referred is preparing for discharge from a non-local PRFTF) the face-to-face interview with the youth may be conducted via telehealth in compliance with federal and state law including La. R.S. 40:1223.1 et seq. and other applicable regulations. The CANS generally assesses the child 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 LOC Decision Model recommends the appropriate level of care for treatment services. The recommendation will automatically be calculated based on the behavioral health algorithm for children when a comprehensive CANS or reassessment is completed.

Initial Evaluation: 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.

6-month Re-evaluation: A CANS must be completed on each child/youth enrolled in CSoC at a minimum of every 6 months, or more frequently if conditions warrant to re-evaluate a child/youth's medical need at a hospital or Nursing facility level of care for continuation in the program. A child/youth will be considered to meet the hospital or nursing facility level of care if the child/youth would be in need of a hospital or nursing facility placement but for the continued receipt of waiver services. The re-evaluation must take into account any clinical evidence of therapeutic clinical goals that must be met before the individual can transition to a less intensive level of care and clinical evidence of symptom improvement. The PIHP will consider information gathered from the CANS as well as any input from the child/youth, family, and the Child and Family Team.

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 LOC 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 LOC determination will automatically be calculated based on the behavioral health algorithm for children set at the same levels as the Louisiana nursing facility and hospital levels of care when the comprehensive CANS or reassessment is completed. This will

result in comparability across eligibility determinations that will be fully comparable to the BHSF nursing facility and Louisiana hospital certification LOC 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:

There are two areas of eligibility a child must meet: Clinical (also called Functional) and Financial (also called Medicaid).

Clinical Evaluation. A Mental Health Professional Licensed for independent practice is responsible for determining clinical eligibility. Key features of clinical eligibility include:

- Age- A child must be between 5 through 20 years old.
- Diagnosis- a DSM mental health diagnosis.
- SED Criteria- All children on the waiver must be identified as SED.
- Inpatient psychiatric hospital criterion criteria: A child must be determined as likely to need an inpatient psychiatric hospital level of care in the absence of waiver services.
- Functional Assessment- All children on the waiver must meet minimum scores for the hospital level of care as determined by the CANS LOC Decision Model.

Note: The initial CANS must be completed by a CANS certified LMHP.

• Case Management Choice and Release of Information Form — Documentation that the parents or caregivers of the child/youth chose the waiver rather than hospitalization or nursing facility placement

Financial Eligibility - If a child is not already eligible for Medicaid, a financial eligibility determination for Medicaid is completed following the LOC determination. A financial redetermination occurs annually.

Semi-Annual Reevaluation - The need for HCBS SED Waiver services are re-evaluated at a minimum of every 6 months, or more often if there are significant changes in behavior, the family and/or the Child and Family Team feel it is appropriate, and/or as goals are completed. The re-evaluation, which must be completed by a CANS certified LMHP, consists of a CANS and a review of available medical and clinical record. The child/youth's continued need for a psychiatric hospitalization or nursing facility level of care.

Notice of Action- When a child is found clinically eligible or ineligible during the initial evaluation or the semi-annual re-evaluation their family will receive a Notice of Action advising them of the status of clinical eligibility.

All clinical eligibility documentation including the initial evaluation, the annual re-evaluation and the notice of action are to be maintained in the child's clinical electronic health record at the Wraparound Agency and the PIHP.

All decisions by the team are reviewed by the PIHP for consistency with State Guidelines.

- 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 re-evaluation timelines, as well as to alert Wraparound Agencies of said timelines. The IMT analyzes reports related to the level of care assurance to ensure re-evaluations are completed timely.

- 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 State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

LOC1: Numerator: Number of initial participants who meet the level of care requirements prior to receipt of services Denominator: Total number of initial participants

Data Source (Select one):

Other

If 'Other' is selected, specify:

PIHP data system

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> State Medicaid Agency		
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 participants whose level of care determination form was completed timely, as required by the State Denominator: Total number of participants

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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:

LOC3: Numerator: Number of participants whose level of care determination was made by a qualified evaluator Denominator: Total number 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +,-5%

<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

LOC4: Numerator: Number of participant 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: PIHP	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

b. Methods for Remediation/Fixing Individual Problems

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

OBH reviews and analyzes level of care performance measure data to ensure the compliance with the sub-assurance. 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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 Agency informs individuals and/or their authorized representatives of the “feasible alternatives” under the waiver and ensure they are provided with a choice of either institutional or home and community-based services during financial eligibility intake (as documented on BHSF Form LTC/CS) and at the time a waiver offer is made (as documented on the “Case Management Choice and Release of Information Form”). This information is also reviewed with individual and/or their authorized representative at the pre-certification home visit conducted by Wraparound Agency staff prior to approval of the initial plan of care.

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 each potential enrollee and enrollees, and must notify enrollees that oral interpretation is available for any language. 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 enrollees, or potential enrollees of a PIHP. Material must be available at no charge in that specific language.

In addition, the DHH 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 services are designed to assist children 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. Independent Living/Skills Building activities are provided in partnership with young children to help the child/youth arrange for the services they need to become employed, access transportation, housing, and continuing education. Services are individualized according to each youth's strengths, interests, skills, goals, and are included on an individualized transition plan (i.e. Waiver Plan of Care). It is expected that Independent Living/ Skills Building activities take place in the community. This service can be utilized to train and cue normal activities of daily living and instrumental activities of daily living. Housekeeping, homemaking (shopping, child care, and laundry services), or basic services solely for the convenience of a child receiving independent living / skills building are non covered. An example of community settings could encompass: a grocery or clothing store, (teaching the young person how to shop for food, or what type of clothing is appropriate for interviews), unemployment office (assist in seeking jobs, assisting the youth in completing applications for jobs), apartment complexes, (to seek out housing opportunities), Laundromats, (how to wash their clothes), Life safety skills, ability to access emergency services, basic safety practices and evacuation, Physical and mental health care (maintenance, scheduling physician appointments); recognizing when to contact a physician, self administration of medication for physical and mental health conditions, understanding purpose and possible side effects of medication prescribed for conditions; other common prescription and non-prescription drugs and drug uses, use of transportation (accessing public transportation, learning to drive, obtaining insurance), etc. These services may be provided in any other community setting as identified through the Plan of Care process. This is not an all inclusive list.

Transportation provided between the child/youth's place of residence and other services sites or places in the community and the cost of transportation is included in the rate paid to providers of this service. Independent Living /Skills Building does not duplicate any other Medicaid State Plan Service or service otherwise available to recipient at no cost.

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

-Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the participant's medical record.

-Independent Living / Skills Building will not duplicate any other Medicaid State Plan service or other services otherwise available to participant 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 and professional 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 1050 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 is designed to benefit the Medicaid eligible child/youth experiencing a serious emotional disturbance who without waiver services would require state psychiatric hospitalization or nursing facility institutionalization. This service provides the training and support necessary to support and 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. The specialist shall attend meetings with the family and assist in helping family members to effectively contribute to planning and accessing services including assistance with removing barriers. The specialist assists in describing the program model and providing information as needed to assist the family. 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 child/youth (e.g., parenting children with various behavior challenges). This involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the Medicaid eligible child/youth in relation to their mental illness and treatment; development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for the child/youth'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 child's diagnoses; understanding service options offered by service providers; and assisting with understanding policies, procedures and regulations that impact the child with mental illness/addictive disorder concerns while living in the community (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. 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:

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
2. Parent Support and Training will not duplicate any other Medicaid State Plan Service or other services otherwise available to the recipient at no cost.
3. Services may be provided concurrent with development of the POC to ensure parent support and training and must be intended to address the needs identified in the assessment and to achieve the goals or objectives identified in the child's individualized plan of care.
4. The Parent Support Specialist must be supervised by a person meeting the qualifications for a Family Support Supervisor.
5. The individuals performing the functions of the Parent Support Specialist may be full-time or part-time (e.g., Parent Support Specialist may be a part-time employee separate and distinct from a part-time Parent Trainer and/or Group Facilitator).

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 and professional 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:

09 Caregiver Support

Sub-Category 1:

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 child/youth in the child'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 relief to families/caregivers of a child with a serious emotional disturbance or relief of the child. The service is designed to help meet the needs of the primary caregiver as well as the identified child. Respite services help to 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, these 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. Short Term Respite Care can be provided in an Individual's home or place of residence or provided in other community settings such as at a relative's home or in a short visit to a community park or recreation center. Respite Services provided by or in an Institution for Mental Disease (IMD) are non-covered. The child must be present when providing Short Term Respite care. Short term Respite care may not be provided simultaneously with Crisis Stabilization Services and does not duplicate any other Medicaid State Plan Service or service otherwise available to recipient at no cost. The Medicaid rate does not include costs for room & board.

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.

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
2. Short Term Respite Care will not duplicate any other Medicaid State Plan Service or other services otherwise available to recipient at no cost.
3. Medicaid federal financial participation (FFP) will not be claimed for the cost of room and board.
4. Respite care may be provided by a Licensed respite care facility, with the availability of community outings. Community outings would be included on the approved POC and would include activities such as school attendance, or other school activities, or other activities the individual would receive if they were not receiving respite from a center-based respite facility. Such community outings would allow the individual's routine not to be interrupted. Respite is not provided inside a provider facility.
5. 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	Respite Care Services Agency
Agency	Crisis Receiving Center
Agency	Child Placing Agency (Therapeutic Foster Care)
Agency	Supervised Independent Living (SIL) Agency
Agency	Personal Care Attendant

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 Administrative Code (LAC) 48:I.Chapter 50
<http://www.doa.la.gov/osr/LAC/48v1/48v01.doc>

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) 28:2180.12 and Louisiana Administrative Code 48:I.Chapters 53 and 54
<http://www.doa.la.gov/osr/LAC/48v1/48v01.doc>

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:**

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
<http://www.doa.la.gov/osr/LAC/48v1/48v01.doc>**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
 http://www.doa.la.gov/osr/LAC/48v1/48v01.doc

Certificate (specify):

Other Standard (specify):

DHH 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: 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:

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:

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 child/youth centered support services that provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Youth Support and Training services have a recovery focus 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 child/youth's individualized POC. The structured, scheduled activities provided by this service emphasize the opportunity for youth to support other children and youth in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Youth Support and Training services include face-to-face intervention with the child/youth present. Services can be provided individually or in a group setting. The majority of Youth Support and Training contacts must occur in community locations where the person lives, works, attends school and/or socializes. This service may include the following components:

- A. Helping the child/youth to develop a network for information and support from others who have been through similar experiences
- B. Assisting the child/youth 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.
- C. Assisting the child/youth to identify and effectively respond to or avoiding identified precursors or triggers that maintain or increase functional impairments.
- D. Assist the child/youth with the ability to address and reduce the following behaviors: reducing reliance on Youth Support and Training over time, rebelliousness 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.

- Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
- 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.**

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 PIHP must complete a Louisiana state check and motor vehicle screen upon the credentialing of the following independent providers of services:

- Transition Coordinator (Individual)
- Direct Support Worker

The PIHP conducts criminal background checks on independent practitioners as well.

The PIHP will ensure that HCBS CSoc waiver agencies and providers meet required DHH-OBH certifications. In addition, the providers must provide evidence that required standards have been met at the time of renewing their license and/or certification.

Provider agencies with direct service providers must also conduct criminal background checks and sex offender checks as well as Louisiana State check and motor vehicle screen 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.

Family Support Organization Agency - Family Cultural Support Specialist/Parent Trainer/Group Facilitator
 Family Support Organization Agency - Peer Support Specialist
 Transition Coordinator Agency – Transition Coordinator
 Agency Personal Care Attendant
 Agency Center Based Respite
 Agency Respite Care Services Agency
 Child Placing Agency (Therapeutic Foster Care)
 Supervised Independent Living (SIL) Agency

Criminal background checks 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 criminal record check policy at the time of initial credentialing of the agency and re-verifies agency credentials, including a sample of criminal background checks, 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 for each employee hired.

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 PIHP must perform criminal and professional background checks, check the State Sex Offender and Child Predator Registry maintained by the State Police Office, and check the Certified Nurse Aide Registry for information on convictions by a CNA for abuse against the elder or infirm.

Licensed agencies who contract with the PIHP must conduct criminal and professional background checks of prospective employees for positions who have direct access to individuals receiving services.

Unlicensed agencies that contract with the PIHP to provide services are also required to conduct criminal and professional background checks of prospective employees who may provide waiver services to child/youths.

The PIHP reviews the provider agency criminal and professional background checks policy at the time of initial credentialing and re-verifies agency credentials, including a sample of criminal and professional background checks screenings, at a frequency determined by the PIHP, no less than every three years. The PIHP reviews agency personnel practices annually to ensure that necessary screenings have been performed prior to employment.

Appendix C: Participant Services

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

c. **Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

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.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

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

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

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

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

Services may be provided by a member of the participant's family, provided that the participant does not live in the family member's residence and the family member is not the 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 or contracted with the PIHP and must meet the same standards as direct support staff that are not related to the individual. Payment for services rendered are approved by prior and post authorization as outlined in the POC.

- 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:

DHH 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 provider's 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, the PIHP and provider must take corrective action and terminate the provider if progress is 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 children enrolled cannot be met. 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 DHH 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 State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: 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:

QPI: 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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, 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +,-5%
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify: <input type="text"/>

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

	<input type="button" value="↑"/> <input type="button" value="↓"/>
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; text-align: center;"> <input type="button" value="↑"/> <input type="button" value="↓"/> </div>

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The State believes the great majority of CSoc members are served in settings that fully comport with the home and community-based setting requirements. We believe 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, we believe all CSoc services are provided in home and community-based settings.

The State will assess all settings, residential and non-residential, through provider self-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. The State will use the resulting information to work with individual providers on remediation to fully comply with the home and community-based setting requirements. On an ongoing basis, the State will ensure continued compliance with these regulations by surveying participants no less than annually 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 will be required to collect information during the enrollment process to ensure the proposed setting comports with the setting requirement and will be required to report to OBH any settings discovered that are not in compliance with the setting requirements.

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

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 State certified Wraparound Agencies. The Wraparound Facilitator must be employed by a Wraparound Agency and meet the following qualifications: have at least a BA/BS degree or be equivalently qualified by work experience or a combination of work experience in the human services field and education with one year of experience, complete Wraparound Facilitation Training according to a curriculum approved by OBH within 6 months of hire, 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 shall include the child/youth, parents or caregivers of the child/youth, behavioral health providers, and other individuals agreed to by the family to participate in the development of the plan of care.

Development of an individualized plan of care: Using the information collected through an assessment, the Wraparound Facilitator convenes and facilitates the Child and Family Team, together with the Team develops a person and family-centered, plan of care that specifies the goals and actions to address the medical, social, educational and other services needed by the eligible individual. The Wraparound Facilitator works directly with the child, the family (or the child's authorized health care decision maker) and others to identify the strengths, needs and

goals of the child and the strengths, needs and goals of the family in meeting the child's needs.

The child/youth and parents or caregivers of the child/youth have the primary role of identifying appropriate goals, strengths, needs, and the development of a risk assessment (crisis plan). Input of all members of the Child and Family Team is used to identify the appropriate, frequency and duration of waiver services, and natural supports that are built into the Plan of Care to assist the child/youth in meeting their goals. The wraparound facilitator plays a role in this process by facilitating the Plan of Care development through documentation of the decisions made by the Child and Family Team, facilitating the overall meeting, and assuring that all members of the team have the opportunity to participate. The child/youth and parents or caregivers of the child/youth have the ability to request a meeting of their Child and Family Team at any time should needs or circumstances change.

The child/youth and parents or caregivers of the child/youth are able to designate a qualified individual of their choosing as the wraparound facilitator.

Additionally, the Family Support Organization's —Parent Support Specialists and Youth Support and Training Specialists provide the 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. Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child. This involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the child in relation to their mental illness and treatment; development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management; assisting the family in understanding various requirements of the waiver process, such as the crisis plan and plan of care process; interpreting choice offered by service providers; and assisting with understanding policies, procedures and regulations that impact the child with mental illness while living in the community. 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, children, relatives, grandparents, or foster parents.

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 child/youth is screened positive on the CANS Brief Screening, the PIHP makes the determination that the child/youth is presumptively eligible for the waiver. The PIHP authorizes services during the initial 30 days to stabilize the child/youth and for any of the specialized services available to children/youth enrolled in the waiver and their families. At the same time, the PIHP sends concurrent written referrals to the Wraparound Agency, a CANS certified LMHP and the Family Support Organization to initiate the process to engage the family and verify eligibility for waiver services.

Wraparound agency (WAA) staff makes the initial contact to the child/youth and/or their parent(s)/ caregiver(s) to set up a face-to-face meeting to provide information on the waiver services. This information includes, but is not limited to: waiver service delivery brochure that describes the waiver services including the option for service delivery settings for the child/youth to receive waiver services in a home/community setting or in a hospital or residential setting, freedom of choice of providers, and how to report abuse and neglect. During this initial meeting, the parent/caregiver is asked to indicate their choice of service delivery settings as evidenced by their signature on the freedom of choice document, indicating the selection of services in the home/community rather than in a residential placement as well as provide informed consent to allow the release of information between the PIHP and the WAA, and the WAA and current service providers. The WAA staff may also provide information to the

child/youth and parent/caregivers on the assessment process such as information on the types of questions that will be discussed during the administration of the CANS and the behavioral assessment.

The PIHP also makes a referral to a CANS certified LMHP to initiate the clinical eligibility assessment process which consists of the CANS Comprehensive Multisystem Assessment and the Individual Behavioral Health Assessment (IBHA). This comprehensive assessment must be completed and submitted to the PIHP within 30 days of the referral. The PIHP staff that serve on the independent review team review the Comprehensive CANS, IBHA, medical / psychiatric records and any other documentation to identify appropriate services to be addressed in the Plan of Care. The child/youth will be enrolled in the 1915(c) waiver if meeting the LOC determination and Medicaid financial eligibility. If the child does not meet LOC and financial eligibility, the appropriate non-Medicaid funding source will be billed and the child/youth will not be enrolled in the waiver. See Appendix G for a description of the appeal rights that any non-Medicaid child/youth will be offered.

The Family Support Organization (FSO) staff will also be in contact with the child/youth and the parent(s)/caregiver (s) to provide information on the waiver services, reinforce the child/youth and family's rights and assist the family in navigating the system. FSO staff has lived experiences and is able to provide support and assistance to the child/youth and family receiving waiver services.

a. The Wraparound Facilitator in the Wraparound Agency is responsible for facilitating the development of the Plan of Care. During the initial meetings with the child/youth and parent(s)/caregivers(s), the wraparound facilitator meets with the family to do a strengths and cultural discovery and assist them in determining their vision for their family. The Wraparound Facilitator also works with the family to identify potential members of the Child and Family Team, such as natural supports and formal supports such as current physical/behavioral health providers. The Wraparound Facilitator is responsible for convening the Child and Family Team to develop the initial waiver specific Plan of Care within 30 days of receipt of referral from the PIHP. The Plan of Care is based on information provided by the child/youth and parent/caregivers through a strengths and cultural discovery, goals and vision, results of the CANS Comprehensive Assessment and input from Child and Family Team members. The Wraparound Facilitator is responsible for ensuring that all members of the team have the opportunity to participate in the development of the Plan of Care. The child/youth and parents/caregivers of the child/youth have the ability to request a meeting of their Child and Family Team at any time should needs or circumstances change. The Wraparound Facilitator is responsible for ensuring that the Plans of Care are submitted to the PIHP within the required timelines.

b. A CANS Comprehensive Multisystem Assessment is completed by an CANS certified LMHP. The CANS addresses the following domains: home, community, financial/economic, health, legal, leisure/recreation, vocational/educational, socialization, and other. Goal development is directly related to the CANS. Goals are established based on the child/youth's needs and interventions for goals are built upon the child/youth's identified strengths. The Child and Family Team identify goals and interventions based upon the CANS and other assessments. Plan of Care goals identified by the child/youth and parents or caregivers of the child/youth are prioritized by the Child and Family Team.

c. The Wraparound Agency staff provides information on the services available through the waiver for the child/youth and parent/caregivers during the initial meeting. The Wraparound Facilitator from the Wraparound Agency continues to provide information on the waiver specific services and also includes services available in the system of care outside of the SED waiver. Examples of such services would be traditional behavioral health services such as medication management and individual therapy provided in the home. 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 also included in the Plan of Care but do not take the place of existing or identified natural supports.

d) The core values of the Community-Based Services are based on the System of Care values and are Strengths-Based, Family-Centered, Culturally Respectful, and Community-Based. These core values are the foundation for the training that is provided to Community-Based Service providers throughout the state. In keeping with these core values, the wraparound process is a participant-driven process where the child/youth and the parents of caregivers of the child/youth 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 first through the Child and Family Team's development of the Plan of Care. It is the responsibility of the Child and Family Team to develop the Plan of Care.

e) The wraparound facilitator guides the process by facilitating wraparound meetings and ensuring the waiver requirements are met. The wraparound facilitator is responsible for assisting the Child and Family Team in identifying resources for the child/youth and the parents or caregivers of the child/youth. The wraparound facilitator is a part of the development process and a member of the Child and Family Team. The Wraparound Facilitator then takes on the responsibility of assuring that the needed resources are implemented for the child/youth and parents or caregivers of the child/youth. The wraparound facilitator guides continuous reassessment and monitoring of the plan through 90-day and semi-annual reviews of the Plan of Care. CANS reassessment is completed by a qualified individual certified in the Louisiana CANS. The Parent Support Specialist and Youth Support Specialist may support the wraparound process and be an ongoing part of the Child and Family Team by helping the youth/family to understand the wraparound process, empowering youth/family to make choices to achieve desired outcomes, and assisting youth/family to uncover resources and natural supports that may be available.

f) The Plan of Care identifies the assigned task and person responsible for implementing the identified support to attain a specific Plan of Care goal. This includes community partners identified by the Child and Family Team to provide natural supports for the family to meet the child/youth's needs. Each Plan of Care has an identified Crisis Plan section which identifies potential crisis, what action steps (strategies) need to be implemented 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 wraparound process. However, a wraparound meeting can be convened at any time in which needs or circumstances have changed or the child/youth and parents or caregivers of the child/youth feel it is warranted, or the needs of the child/youth require the Child and Family Team to meet on a more frequent basis to best coordinate care.

The child/youth and parents or caregivers of the child/youth must be involved in the development of the Plan of Care. Participation is documented through the signatures of the child/youth and parents or caregivers of the child/youth on the Plan of Care. In addition, the PIHP must operate from one integrated treatment plan. This reinforces the wraparound process and results in the Plan of Care encompassing all services that may be accessed through the PIHP.

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 Plan of Care is required to contain a crisis plan. Crisis plans are developed in conjunction with the Plan of Care during the wraparound meeting based upon the individualized preferences of the child/youth and parents/caregivers. As with the Plan of Care itself, the child/youth and parents/caregivers may choose to revise the crisis plan at any time they feel it is necessary. Each crisis plan is individualized to the child/youth. A potential crisis (risk) and appropriate interventions (strategies to mitigate risk) are specific to the child/youth and identified by the Child and Family Team. 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.

The crisis plan includes action steps as a backup plan if the crisis cannot be averted. The action steps are developed through the wraparound process by the Child and Family Team and incorporated in the crisis plan. The action steps may involve contacting natural supports, calling a crisis phone line, or contacting the wraparound facilitator. The PIHP is required to provide 24 hours a day/365 days a year crisis response that is readily accessible to child/youths and their parents/caregivers. A required component of the crisis plan is the contact information for those involved at all levels of intervention during the crisis. Families are provided a copy of the crisis plan as an attachment to their Plan of Care in order to have access to the identified information should a crisis occur.

Should a crisis occur or support worker not arrive for a scheduled appointment, individual contact information is included on the crisis plan. The PIHP is required to have staff on-site available by 800 phone number 24 hours a day/365 days a year to respond to calls.

Short-term respite are services which may be included in a Plan of Care if the Child and Family team deems that the youth and family need those services to give relief to the caregiver (short-term respite). Because each child is unique, the Wraparound Facilitation undertaken by the Child and Family Team designs a child specific Plan of Care including a crisis plan and a back-up plan. The backup plan must be an individualized backup plan and include action steps for the individual to follow in the event of an emergency, including the failure of a support worker to appear when scheduled. Should a crisis occur or support worker not arrive for a scheduled appointment, individual contact information is included on the crisis plan. The PIHP is required to have staff on-site available by 800 phone number 24 hours a day/365 days a year to respond to calls and may include arranging for designated provider agencies to furnish staff support on an on-call basis as necessary. The Wraparound Facilitator and Child and Family Team must ensure that an effective back-up plan is crafted to meet the unique needs and circumstances of each youth.

The crisis plan and backup plan must include the identification of potential risks to the enrolled youth and the development of strategies to mitigate such risks. Critical risks must be addressed by incorporating strategies into the plan to mitigate whatever risks may be present. The CANS assessment is used to systematically identify potential risks. Strategies to mitigate risk should be designed to respect the needs and preferences of the waiver participant and may include waiver respite services (short-term respite) or crisis intervention/stabilization services (State Plan). The Wraparound Facilitator must also be available to assist in the event of crises or staff member no shows.

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.

Children/youths and their families will have free choice of providers within the PIHP network and may change providers as often as desired. Once enrolled in the PIHP, if a child/youth is already established with a therapist who is not a member of the network, the PIHP is required to make every effort to arrange for the child/youth to continue with the same provider if the child/youth so desires. The provider would be requested to meet the same qualifications as other providers in the network. In addition, if a child/youth needs a specialized service that is not available through the network, the PIHP will arrange for the service to be provided outside the network of a qualified provider is available. Finally, except in certain situations, participants will be given the choice between at least two providers. Exceptions would involve highly specialized services which are usually available through only one agency in the geographic area. This information is provided in the PIHP's member handbook which is given to participants upon enrollment in the waiver. Member handbooks are also on the PIHP 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):

The Child and Family Team develop the plan of care using the Strengths and Needs assessment developed by the LMHP. Once developed, that same information is submitted electronically for prior authorization to the PIHP's Care Management team through the electronic health record and other applicable databases. The PIHP staff complete the cost of care calculation and verify POC cost meets cost of care requirements as part of the POC approval process. Any communications necessary as part of the approval process occur between the WAA and PIHP to ensure that the POC is received, reviewed, and processed in a timely manner. The PIHP provides Medicaid-reimbursable mental health services (including waiver services) under the OBH's oversight. The OBH maintains a MOU with the State Medicaid Agency regarding waiver program management which is inclusive of the service plan. The service plan approval is delegated to the OBH by the Medicaid Agency through the MOU.

The State Medicaid Agency monitors the waiver through a review of reporting data provided at the IMT meetings that is obtained through record reviews.

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:

The Plan of Care is reviewed every 90 days with the child/youth and parents/caregivers. The Plan of Care is updated at a minimum on a semi-annual basis through the wraparound process. However, a wraparound meeting can be convened at any time in which needs or circumstances have changed for the child/youth of the child/youth and parents/caregivers feel it is warranted, or the goals of the child/youth have been met.

- 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 RS 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 contacting the participant/family at least once per month to ensure the plan of care is being implemented and to monitor the participant's health and safety. Specifically, plan of care monitoring should include, but is not limited to: child/youth access to waiver services identified in the plan of care; freedom of choice of providers; determination if the services are meeting the need of the child/youth; effectiveness of the crisis plan; child/youth's health and welfare; child/youth's access to non-waiver services in the plan of care, including health services; and methods for prompt follow-up and remediation of all identified problems. In addition, the Wraparound Facilitator is responsible for holding, at minimum, one face to face child and family team meeting every 90 days, with the child/youth and family and identified team members to ensure the following: monitoring of the implementation of the plan of care, including the child/youth's health, safety and welfare. The monitoring of the Plan of Care should include, but is not limited to: child/youth access to waiver services identified in the plan of care; freedom of choice of providers; determination if the services are meeting the need of the child/youth; effectiveness of the crisis plan; child/youth's health and welfare; child/youth's access to non-waiver services in the plan of care including health services; and methods for prompt follow-up and remediation of all identified problems.

- 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 State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: 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 participants whose plan of care include supports and services consistent with assessed health needs, including risks Denominator: Total number 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +,-5%
<input checked="" type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: PIHP		Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

POC1: Number and percent of participants whose plan of care reflects supports and services necessary to address the participant's goals # of participants whose plan of care reflects supports and services necessary to address the participant's goals / total number 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	

		<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +,-5%
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 participants who participated in the plan of care development, as documented by the participant's and parents/caregiver's signature on the plan of care # of participants who participated in the plan of care development / 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +,-5%
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
Specify: PIHP	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

POC4: Numerator: Number of participants whose plans of care were updated timely Denominator: Total number of participants

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

POC5: Numerator: Number of participants whose plans of care were updated when their needs changed 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +,-5%
<input checked="" type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: PIHP		Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 participants who received waiver services in the type, amount, duration, and frequency specified in the plan of care Denominator: Total number of participants enrolled for at least 30 days

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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

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:

POC7: Number and percent of participants given a choice among service providers, as documented by the participant/authorized representative's signature on the State-approved form # of participants given a choice among service providers / total number 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +,-5%
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

	<input type="text"/> ^ v	
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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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

POC8: Number and percent of participants who received information on available waiver services, as documented by the participant/authorized representative's signature on the State-approved form. # of participants who received information on available waiver services / total number 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +,-5%
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

b. Methods for Remediation/Fixing Individual Problems

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

OBH reviews and analyzes plan of care performance measure data to ensure compliance with the sub-assurances. 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> Other Specify: PIHP	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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/participants 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. Applicants/participants are required to access the PIHP's internal appeal process before requesting a hearing with the State.

Upon enrollment, the PIHP sends each enrollee a brochure explaining Medicaid appeal rights. For children/youth and their families with limited literacy, the Wraparound Facilitator verbally explains their appeal rights during the initial home visit. In addition, per 42 CFR 438.406(a)(1), the PIHP will be required to give enrollees 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. All individuals enrolled in the CSoc will be able to access a family cultural support specialist who can assist the family in addition to the requirements of the PIHP, wraparound facilitator and advocacy organizations. When applicants/children/youths are denied participation in the waiver or specific waiver services are denied, terminated, suspended or reduced, the PIHP sends a written notice to the individual explaining the reason for the adverse action, instructions on how to access a fair hearing, 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 level hearing 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 child/youth a minimum of 10 days before the service is actually reduced, terminated or suspended.

As stated above, applicants/child/youths must avail themselves of the appeal process offered by the PIHP before accessing the state fair hearing process. If the applicant/child/youth requests a hearing, 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 with the State. Applicants/child/youths may then request an informal appeal with the Louisiana DHH check process and/or a formal appeal with the Louisiana Division of Administrative Law (DAL) (from <http://www.adminlaw.state.la.us/>)

When the suspension, reduction or termination of service is appealed, child/youths may continue to receive services up through the final decision by the State Fair Hearing as long as they meet the appeal deadlines, the original period covered by the authorization has not expired and the child/youth requests continuation of the service.

BHSF eligibility staff utilize the Adequate Notice of Home and Community Based Services (Waiver) Decision Form 18-W to notify individuals by mail if they have not been approved for Medicaid financing of Home and Community Based Waiver services due to financial ineligibility. A separate page is attached to this form entitled "Your Fair Hearing Rights". This page contains information on how to request a fair hearing, how to obtain free legal assistance, and a section to complete if the individual is requesting a fair hearing. If the child/youth does not return this form, it does not prohibit his right to appeal and receive a 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 Hearings 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 “action” and a grievance process for addressing grievances (complaints). “Actions” 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:

The PIHP is responsible for receiving, reporting, and responding to grievances received for all enrolled child/youths. The OBH and Bureau of Health Services Financing (BHSF) oversee this process through the IMT meeting process.

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 report all grievances under 42 CFR 438 Subpart F made to DHH at least quarterly. The report must include a summary of the grievance, the action taken by the PIHP to address the grievance, the final disposition resolution, and dates of all actions. This report is reviewed during the IMT meeting in order to develop strategies for system improvement as needed.

The PIHP is required to accept and dispose of all grievances consistent with the policies and procedures and timelines in 42 CFR 438 Subpart F. The PIHP must dispose of each grievance and provide notice, as expeditiously as the enrollee’s health condition requires, within State-established timeframes not to exceed 90 days from the day the PIHP receives the grievance.

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 events and incidents involving waiver participants to the OBH, which is consistent with state law (e.g., the Louisiana Children's Code, Title 6, Article 612). 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 <18 years of age and the alleged perpetrator is considered a caregiver (family or paid). Such incidents shall be reported to the local DCFS office. They investigate, protect, and monitor. This jurisdiction is in addition to that of any appropriate licensing regulatory agency.

For youth 18-21, the Louisiana Revised Statutes 14:403.2 outlines definitions and reporting responsibilities. The Bureau of Adult Protective Services is designated by the Louisiana Department of Health and Hospitals 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 DHH 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:

-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)
- 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).
- 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).
- 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)
- 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 DHH 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., DHH 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 PIHP and 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. The PIHP enters the critical incident information into the tracking system and forwards to OBH within 24 hours of the incident.

- 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 child/youth 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 DHH clients as alleged victims and/or DHH 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 DHH.

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 (Children's Code (Article 610)).
2. The Health Standards Section of the DHH 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 Department of Health and Hospitals (DHH) 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 DHH 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 DHH clients where the accused is an employee of DHH or an affiliate will be investigated by the Bureau of Adult Protective Services. DHH 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 DHH are listed in RS 14:403.2 C & D and RS 40, 2009.13B. Should any allegations arise involving DHH 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 PIHP is required to report all critical incidents and events to the OBH. A multi-agency Memorandum of Understanding delineates the responsibility for oversight of the reporting and response to critical incidents or events that affect waiver child/youth. DCFS has the responsibility for investigating those critical incidents referred to them involving abuse, neglect, misappropriation, extortion and exploitation.

Quality Management Responsibilities:

The OBH will utilize the information and data collected on critical incidents for quality management purposes, including but not limited to the following:

Development and review of reports to assure that follow-up and case closure of critical incidents occur according to this policy on an on-going basis for individual cases and quality review of aggregate data;

- Quarterly analysis of data to identify trends and patterns for effective program management that ensures the safety and well-being of people receiving the OBH supports and services and ensures that people receive quality of supports and services from the OBH;
 - Annual analysis of data to determine the effectiveness of quality enhancement goals and activities; and
- Identification of child/youths who experience frequent critical incidents and will need strategies to mitigate risk included in their Plan of Care on an on-going basis.

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 PIHPs are responsible for informing participants of their right to be free from restraints and seclusion via a State-approved form, which is reinforced by the Wraparound Agency.

Wraparound Agencies monitor participants through monthly telephone contact and quarterly face-to-face contact to ensure that these rights are maintained. Oversight of providers is conducted by the PIHPs.

At least quarterly, OBH analyzes, tracks, and trends critical incident data for the use of restraints or seclusion to determine if improvement strategies are indicated.

- 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 PIHPs are responsible for informing participants of their right to be free from restraints and seclusion via a State-approved form, which is reinforced by the Wraparound Agency.

Wraparound Agencies monitor participants through monthly telephone contact and quarterly face-to-face contact to ensure that these rights are maintained. Oversight of providers is conducted by the PIHPs.

At least quarterly, OBH analyzes, tracks, and trends critical incident data for the use of restraints or seclusion to determine if improvement strategies are indicated.

- 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:

PIHPs are responsible for informing participants of their right to be free from restraints and seclusion through the Rights and Responsibilities form.

Wraparound Facilitators monitor participants through monthly telephone contact and quarterly face-to-face contact to ensure these rights are maintained. If the Wraparound Facilitator is informed about or discovers restraint or seclusion use, the Wraparound Facilitator will notify the appropriate Protective Services Agency and the PIHP, as appropriate. Oversight of providers is conducted by Health Standards and the PIHP.

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).

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v

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:

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v

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.

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v

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

a. Methods for Discovery: 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 instances of 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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:

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +,-5%
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
	Specify: <input type="text"/>

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>

<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +,-5%
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

b. Methods for Remediation/Fixing Individual Problems

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

OBH will review and analyze individual-level performance data to ensure that each identified instance of non-compliance is addressed appropriately to ensure compliance with the sub-assurance. If compliance falls below 100% for performance measures HW1, HW2, and HW4, OBH will require the PIHP to complete a quality improvement plan to include a root cause analysis, proposed interventions and associated action steps to address the instance of non-compliance, and methods and associated timelines for evaluating the success of the plan. In addition, OBH will required the PIHP to complete a quality improvement plan inclusive of the same components outlined above if compliance falls below 86% for performance measures HW3 and HW5.

- ii. **Remediation Data Aggregation**

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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 2)

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;
- 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 2)

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 participant satisfaction surveys, programmatic and administrative evaluations, and stakeholder input. OBH uses waiver-specific performance measures to monitor program

performance and trends performance measure results in order to capture areas that require action or attention. OBH relies on a variety of resources to prioritize changes, including information obtained from quality monitoring reviews, analysis of performance measure data, feedback from participants and stakeholders, and legislative and federal mandates.

ii. System Improvement Activities

Responsible Party (check each that applies):	Frequency of Monitoring and Analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input type="checkbox"/> Annually
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Other Specify: <input type="text"/>

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.

Oversight of the concurrent waivers is performed by an Interdepartmental Monitoring Team (IMT), chaired by OBH staff, with representation from DHH Medicaid. The IMT committee 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 participants, stakeholders, providers, and Wraparound Agencies. At quarterly IMT meetings, IMT 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 IMT meets with the PIHP to discuss any identified issues or concerns.

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 IMT, in conjunction with the External Quality Review Organization (EQRO), also conduct an annual review of the PIHP's operations. A written report of findings is generated and a plan of correction for deficiencies is implemented if needed. Progress with the plan of correction is tracked by the IMT at least quarterly.

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

The IMT reviews the QIS and its deliverables on at least a semi-annual basis and will provide updates to CMS when appropriate. Evaluation of the QIS is the responsibility of the IMT and will take into account the following elements:

- Compliance with federal and state regulations and protocols
- Effectiveness of the strategy in improving care processes and outcomes
- Effectiveness of performance measures used for discovery
- Relevance of the strategy with current practices

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. The Division of Fiscal Management, OBH Fiscal staff, and the contract monitor will each receive a copy of the annual audit. The Division of Fiscal Management 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 accounting system shall separately maintain records pertaining to the services and any other costs and expenditures made under this Contract separately for each funding stream.

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 six years thereafter.

The Contract awarded by the State and all subcontractors shall include a provision that CMS, the HHS awarding agency, the US Comptroller General, HHS Inspector General, or any authorized federal representatives, shall have access to any books, documents, papers, and records of the PIHP or subcontractors which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts, and transcriptions. HHS awarding agencies, the HHS Inspector General, the US Comptroller General, or any of their duly authorized representatives has the right of timely and unrestricted access to any books, documents, papers, or other records of the PIHP or subcontractors that are pertinent to the awards, in order to make audits, examinations, excerpts, transcripts and copies of such documents. This right also includes timely and reasonable access to the subcontractors' personnel for the purpose of interview and discussion related to such documents. The rights of access in this paragraph are not limited to the required retention period, but shall last as long as records are retained.

Single Audit Act/QMB A-133:

This 1915(c) waiver program operates concurrently with the 1915(b) waiver. The §1915(b) waiver financial accountability requirements apply. Under such arrangements, the state does not make payments directly to waiver providers but instead makes payments to the managed care entities for the delivery of waiver services and the entities in turn pay 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. LDH ensures the integrity of payments to managed care entities through provisions of the state's contract with managed care entities.

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 Type II requirements. The audit period must be 12 consecutive months with no breaks between subsequent audit periods.

Independent Audit:

The PIHP is required to secure an independent financial audit but individual non-profit and governmental CSoc waiver providers must secure independent financial audits if they receive more than \$750,000 in federal funds (OMB A-133). This is a condition of the Medicaid provider agreement. The State of Louisiana is required to secure an independent audit through an independent CPA as part of the Single Audit Act.

The PIHP shall submit an annual independently audited financial report that specifies the PIHP's financial activities under the Contract within 6 months following the end of the fiscal year. The report should be sent to the DHH Division of Fiscal Management (DFM).

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 prior approve a format for additional reporting requirements that will provide information regarding 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 payments and non-risk Medicaid mental health payments;
3. Third party liability payment made by other third-party payers;
4. Receipts received from other insurers;
5. A breakdown of the costs of service provision, administrative support functions, plan management including documentation of the PIHP's compliance; and
6. Assessment of the PIHP's compliance with financial requirements or the Contract including compliance with requirements for insolvency protection surplus funds, working capital, and any additional requirements; and a separate letter from the independent Certified Public Accountant addressing non-material findings, if any.

The PIHP will be required to comply with other prescribed compliance and review procedures. In addition to the annual audit, the PIHP shall be required to submit to the OBH copies of the quarterly NAIC financial reports. A final reconciliation shall be 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 completed within six months of the end of the Contract year. The final reconciliation shall be completed no later than twelve months following the end of the Contract year.

This is a managed care program through the non-risk plan. 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: There are 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).

Both State and plans must:

- Intake and review fraud/abuse complaints (via published phone and online resources)
- Review/verify claims were rendered as billed (via State or plan-initiated audits/cases and regular EOB and sampling procedures)
- Ensure no payments are made to providers barred from participation in Medicare and Medicaid (via monthly exclusion database reviews)

- Report all suspected provider fraud to State and Attorney General’s Medicaid Fraud Control Unit (via State Program Integrity contacts, using approved referral form if the referral is made by a health plan)
 - Report all suspected member fraud to State eligibility unit (via State Program Integrity contacts)
- State must also:
- Publish State provider exclusions and terminations to the State Adverse Actions Website: <https://adverseactions.LDH.la.gov/> (via Provider Enrollment)
 - Report for-cause provider terminations from Medicaid participation to CMS (via Provider Enrollment/TIBCO applications)
 - Report State fraud and abuse recoveries to CMS (via CMS 64 report)
- PIHP must also:
- Report for-cause health plan provider agreement terminations to State (via Program Integrity contacts within seven days of termination, and quarterly on the approved quarterly FWA report)
 - Report all audits/cases and recoveries to State (via quarterly FWA report)
 - Meet with State at State’s request to discuss fraud activities (via State Program Integrity contacts)
 - Comply with directives from the State to suspend provider payments due to a credible allegation of fraud (State provides memo to all plans, each plan suspends payments and notifies its network provider within five days)

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: 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: Numerator: # of paid claims that are coded according to the service rendered Denominator: total # of paid claims reviewed

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +,-5%
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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: Numerator: # of claims that paid at the Medicaid-approved rate in effect on the date the waiver service was rendered Denominator: total # of paid claims

Data Source (Select one):

Financial audits

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
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 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. If compliance falls below 86% for performance measure FA1, OBH will require the PIHP to complete a quality improvement plan inclusive of the elements stated above.

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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).

Providers are reimbursed on a statewide fee for service basis for Independent Living/Skills Building, Parent Support and Training, Youth Support and Training and Short-term Respite. The provider receives a fixed, pre-determined fee for a single service for a designated period of time. The fee schedule, or provider fees, for this program are published for all providers at <http://new.dhh.louisiana.gov/index.cfm/page/2248> for CSoC procedure codes and rates on the last page of the document, Medicaid Behavioral Health Fee Schedule last updated on 12/27/2016. The fee schedule has no regional variation. There is no cost settlement.

The LA Office of Behavioral Health contracted with Mercer Government Human Services Consulting (Mercer) to develop the fees for those services that are paid based on a statewide fee schedule. In developing fees for these services, a market-based pricing methodology was used.

This methodology includes a review of the service definitions, applicable regulations, provider qualifications and staffing requirements, along with discussions with LA Medicaid and the Office of Behavioral Health regarding the vision and expectations for service delivery. The market-based pricing methodology contained an analysis of four key components: direct care salary expenses, employee related expenses, program related expenses and non-benefit expenses. Allowable cost components were identified to reflect costs reasonable, necessary and related to the delivery of services under the Coordinated System of Care (CSoC) waiver. Market-based research was performed to inform the development of assumptions for cost components and these assumptions were then used to model the fees for each service.

In developing the fees for each of the fee schedule services, information from the U.S. Bureau of Labor Statistics (BLS), information from comparable services from other programs and web-based research was performed. The detailed assumptions used to develop the final fees are considered proprietary and confidential and have not been made publicly available by the State.

A description for each of the key components of the market-based pricing methodology is provided below.

- Direct Care Salary Expenses – This includes direct care wages for the type of staff required to deliver the service as indicated in the service definition.
- Employee-Related Expenses – This includes employee related expenses the provider is responsible for on behalf of the staff hired to deliver, or oversee the delivery of, the waiver service. This includes considerations for items such as the employer’s portion of health insurance, worker’s compensation and employer taxes.
- Program-Related Expenses – This includes consideration for expenditures incurred by the provider through the delivery of the service but expenditures that are not directly billable. This methodology includes consideration for supervisor wages, productivity, employee training, documentation and transportation (if applicable to a given service).
- Non-Benefit Expenses – This includes consideration for general administrative expenses such as administrative staff salaries, administrative building costs, insurance and IT needs.

The information used under this methodology was to develop fees that comply with the requirements of Section 1902(a)30(A) of the Social Security Act (i.e., “payments are consistent with economy, efficiency and quality of care and are sufficient to enlist enough providers”) and the related federal regulations at 42 CFR 447.200 – 205. The Louisiana Department of Health/Financial Management reviews the fees, as well as provider enrollment and retention, to ensure adequate access to these services and adequacy of payments are maintained (see below).

In accordance with 42 CFR 441.310(a)(2), CMS does not allow FFP to be claimed for room and board costs except as part of respite services when provided in a licensed or certified respite facility and not a private residence. Room and board costs are not included in the fees for any of the services in the CSoc waiver including respite.

LA Medicaid made the fee development methodology and fee schedule available to waiver participants, providers and the public through the newspaper, Louisiana Register and rulemaking process as outlined in the public comment section of the waiver (10/28/2016 notices in newspapers, Louisiana Register and to tribes as well as rulemaking process for proposed effective date of 3/1/2017). While the State does not intend to modify the fee development methodology over the course of this waiver renewal period, LA Medicaid and the Office of Behavioral Health will amend the waiver and provide CMS with the updated methodology, as well as follow the public process requirements, if that occurs.

The state assures that it will not modify this methodology for the life of the waiver period. There are no participant directed services in this waiver. Louisiana Medicaid and the Office of Behavioral Health have reviewed the methodology to ensure economy, efficiency, quality of care and found it to be sufficient to meet these requirements and recruit enough providers.

These fees comply with the requirements of Section 1902(a) (30) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care.

Except as otherwise noted in the Plan, the State-developed fee schedule is the same for both governmental and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the Louisiana Register.

Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. Periodically is defined as with each waiver renewal; or any time an access complaint is received from a provider or beneficiary; or if there is a lack of provider capacity for a service needed by a child.

To monitor for rate sufficiency, the following approaches have been taken under the past waiver and will be taken under the future waiver period:

- Analyze and incorporate feedback from stakeholders. This approach includes evaluating feedback from individuals, families, independent case managers, advocacy groups and providers about the adequacy of direct service providers and collecting data on fair hearings, grievances and appeals related to lack of providers.
- Collect evidence from QIS D, sub-assurance d – This approach includes review of evidence related to the performance measures outlined in QIS D, sub-assurance d, which reviews whether services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan. This evidence includes the specific performance measure that assess whether services are delivered as outlined in the service plans by qualified individuals. The review starting in year four of the past waiver includes determining the reasons that individuals are not receiving services in accordance with the service plan.
- Measure changes in provider capacity – This approach includes measuring the change in the number of the new providers and these providers' capacity as well as service utilization of enrollees and comparing the capacity and service utilization information to the previous years' data.

- 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 DHH 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 non-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. The Medicaid fee schedule used to establish the invoices is equal to or less than the maximum allowable under the same Medicare rates, if applicable. If a service has no Louisiana-specific Medicare rate, 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 any 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 non-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. *Select one:*

- 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.**

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 risk payments to the PIHPs are based on expenditures for services in the FFS waiver. FFS payment rates are based on the cost of providing the service exclusive of room and board. Other funding sources are 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	4078.30	13900.11	17978.41	7456.99	23382.69	30839.68	12861.27
2	4239.04	14428.31	18667.35	7740.36	24271.23	32011.59	13344.24
3	4399.83	14976.58	19376.41	8034.49	25193.54	33228.03	13851.62
4	4564.97	15545.70	20110.67	8339.80	26150.89	34490.69	14380.02
5	4737.62	16136.43	20874.05	8656.71	27144.63	35801.34	14927.29

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	4600	4598	2
Year 2	4600	4598	2
Year 3	4600	4598	2
Year 4	4600	4598	2
Year 5	4600	4598	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 199 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 for these estimates is as follows:

The state has updated the factor D to reflect the actual 372 data and inflation rate experienced under the waiver. Crisis Stabilization has been removed as a waiver service. Please note: the waiver was new the year ending March 2013. Since that time the waiver has been ramping up in both number of users as well as in units per user. From the 372 report, we have the following data from the first three years. In waiver year one, Louisiana had 199 unduplicated users and spend \$175,982. D was \$884. In waiver year two, Louisiana had 612 unduplicated users and spent \$832,539. D was \$1,360. In waiver year three, Louisiana had 1,742 unduplicated users and spent \$6,363,588. D was \$3,653. The 372 overall trend rate from 2014-2015 on the 372 report was a growth in users of 185% and a growth in D costs of 169%.

The 372 report for year four is not yet final. Preliminary data from the waiver year 4 shows that in 2016 the unduplicated waiver users actually grew to 3,933 while costs grow to \$10,151,401 (for the 2400 waiver slots). In 2017, the unduplicated waiver users is already 4,596 but the claims are not yet complete so a cost figure is not available. The State used a scaling factor to go from the 1,742 unduplicated FY14-15 to 4,600 and applied to the user level of each service from FY14-15 to get the Waiver year user counts in the renewal.

Because the program is still ramping up and has not yet “leveled” off at a maintenance level of inflation, Louisiana is inflating the 372 data from year 3 at the actual trend rates to reflect 2016 actual costs. After that point, Louisiana used 3.8% CPI to the cost/user of each waiver service in FY 14-15 to get to the Waiver Year 1 cost/user by service, and then multiplied the updated cost/user by the projected users of each service scaled up to 4,600 total unduplicated ($1,742 / 4,600 \times \text{FY 14-15 User count by service}$). Adding these waiver service costs together and dividing by 4,600 gives us Waiver Year 1 Factor D of \$4,084. For years, 2-5 of the renewal, Louisiana has applied the CPI-U inflation rate of 3.8% using the compound formula: $[\text{Component Cost} \times (1 + \text{trend } \%)^{(\text{month}/12)}]$, which is much lower than actual trend rates because it is assumed that the “ramp up” period is finished after year 1 of the upcoming waiver period. No Medicare part D drug costs are included.

3.8% is the Medical Care Annual Moving Average Trend for the fourth quarter of 2016, coming from the Bureau of Labor Statistics Consumer Price Index For details, see <http://www.bls.gov/cpi/cpifact4.htm>

- 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 372 report was \$12,901 with an inflation rate of 3.3% from 2014-2015 and 9% from 2013-14. Because of the continuing ramp up of the program and the wide divergence of trend rates, a trend rate of the CPI-U (3.8%) was utilized to annually inflate the D' using the formula: $[\text{Historical D}' \times (1 + \text{trend } \%)^{(\text{month}/12)}]$. The waiver year 1 D' is \$13,900 because 2 years' of CPI-U trend were utilized to inflate from Waiver Year 3 of the last waiver period to Waiver Year 1 of the renewal.

- 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 372 report was \$6,921 with an inflation rate of 17% from 2014-2015 and -18% from 2013-14. Because of the continuing ramp up of the program and the wide divergence of trend rates, a trend rate of the CPI-U (3.8%) was utilized to inflate the G using the formula: $[\text{Historical G} \times (1 + \text{trend } \%)^{(\text{month}/12)}]$. The State's data only includes information from NF and hospital level of care. No Medicare

part D drug costs are included. The waiver year 1 G is \$7,457 because 2 years' of CPI-U trend were utilized to inflate from Waiver Year 3 of the last waiver period to Waiver Year 1 of the renewal.

- 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 372 report was \$21,702 with an inflation rate of 31% from 2014-2015 and 27% from 2013-14. Because of the continuing ramp up of the program and the large unsustainable trend rates, a trend rate of the CPI-U (3.8%) was utilized to inflate the G' using the formula: $[\text{Historical G}' \times (1 + \text{trend } \%)^{\text{month}/12}]$. Factor G' is greater than D' because it includes PRTF and hospital costs. While the individuals on the waiver may only go into a hospital for a limited amount of time before being disenrolled, the comparable individuals not on the waiver could be admitted into a hospital AND reside in a PRTF for a length of time. The comparable population must at least be eligible for hospital level of stay. The waiver year 1 G' is \$23,383 because 2 years' of CPI-U trend were utilized to inflate from Waiver Year 3 of the last waiver period to Waiver Year 1 of the renewal.

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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Living/Skills Building Total:							2138572.80
Independent Living/Skills Building	<input type="checkbox"/>	15 minute	1088	252.00	7.80	2138572.80	
GRAND TOTAL:							18760182.20
Total: Services included in capitation:							
Total: Services not included in capitation:							18760182.20
Total Estimated Unduplicated Participants:							4600
Factor D (Divide total by number of participants):							4078.30
Services included in capitation:							
Services not included in capitation:							4078.30
Average Length of Stay on the Waiver:							199

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Parent Support and Training Total:							6115709.20
Group	<input type="checkbox"/>	15 minute	594	24.00	3.23	46046.88	
Individual	<input type="checkbox"/>	15 minute	3457	136.00	12.91	6069662.32	
Short-Term Respite Total:							678857.40
Short-Term Respite	<input type="checkbox"/>	15 minute	433	402.00	3.90	678857.40	
Youth Support and Training Total:							9827042.80
Group	<input type="checkbox"/>	15 minute	676	32.00	3.23	69871.36	
Individual	<input type="checkbox"/>	15 minute	3499	216.00	12.91	9757171.44	
GRAND TOTAL:							18760182.20
Total: Services included in capitation:							18760182.20
Total: Services not included in capitation:							18760182.20
Total Estimated Unduplicated Participants:							4600
Factor D (Divide total by number of participants):							4078.30
Services included in capitation:							4078.30
Services not included in capitation:							4078.30
Average Length of Stay on the Waiver:							199

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 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 2

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Living/Skills Building Total:							2214950.40
Independent Living/Skills Building	<input type="checkbox"/>	15 minute	1088	261.00	7.80	2214950.40	
Parent Support and Training Total:							6340777.17
Group						47965.50	
GRAND TOTAL:							19499562.74
Total: Services included in capitation:							19499562.74
Total: Services not included in capitation:							19499562.74
Total Estimated Unduplicated Participants:							4600
Factor D (Divide total by number of participants):							4239.04
Services included in capitation:							4239.04
Services not included in capitation:							4239.04
Average Length of Stay on the Waiver:							199

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	<input type="checkbox"/>	15 minute	594	25.00	3.23		
Individual	<input type="checkbox"/>	15 minute	3457	141.00	12.91	6292811.67	
Short-Term Respite Total:							705876.60
Short-Term Respite	<input type="checkbox"/>	15 minute	433	418.00	3.90	705876.60	
Youth Support and Training Total:							10237958.57
Group	<input type="checkbox"/>	15 minute	676	34.00	3.23	74238.32	
Individual	<input type="checkbox"/>	15 minute	3499	225.00	12.91	10163720.25	
GRAND TOTAL:							19499562.74
Total: Services included in capitation:							19499562.74
Total: Services not included in capitation:							4600
Total Estimated Unduplicated Participants:							4239.04
Factor D (Divide total by number of participants):							
Services included in capitation:							4239.04
Services not included in capitation:							
Average Length of Stay on the Waiver:							199

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 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 3

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Living/Skills Building Total:							2299814.40
Independent Living/Skills Building	<input type="checkbox"/>	15 minute	1088	271.00	7.80	2299814.40	
Parent Support and Training Total:							6606695.91
Group	<input type="checkbox"/>	15 minute	549	26.00	3.23	46105.02	
Individual						6560590.89	
GRAND TOTAL:							20239236.18
Total: Services included in capitation:							20239236.18
Total: Services not included in capitation:							4600
Total Estimated Unduplicated Participants:							4399.83
Factor D (Divide total by number of participants):							
Services included in capitation:							4399.83
Services not included in capitation:							
Average Length of Stay on the Waiver:							199

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	<input type="checkbox"/>	15 minute	3457	147.00	12.91		
Short-Term Respite Total:							731207.10
Short-Term Respite	<input type="checkbox"/>	15 minute	433	433.00	3.90	731207.10	
Youth Support and Training Total:							10601518.77
Group	<input type="checkbox"/>	15 minute	676	35.00	3.23	76421.80	
Individual	<input type="checkbox"/>	15 minute	3499	233.00	12.91	10525096.97	
GRAND TOTAL:							20239236.18
Total: Services included in capitation:							
Total: Services not included in capitation:							20239236.18
Total Estimated Unduplicated Participants:							4600
Factor D (Divide total by number of participants):							4399.83
Services included in capitation:							
Services not included in capitation:							4399.83
Average Length of Stay on the Waiver:							199

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 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 4

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Living/Skills Building Total:							2393164.80
Independent Living/Skills Building	<input type="checkbox"/>	15 minute	1088	282.00	7.80	2393164.80	
Parent Support and Training Total:							6835542.98
Group	<input type="checkbox"/>	15 minute	594	27.00	3.23	51802.74	
Individual	<input type="checkbox"/>	15 minute	3457	152.00	12.91	6783740.24	
GRAND TOTAL:							20998873.84
Total: Services included in capitation:							
Total: Services not included in capitation:							20998873.84
Total Estimated Unduplicated Participants:							4600
Factor D (Divide total by number of participants):							4564.97
Services included in capitation:							
Services not included in capitation:							4564.97
Average Length of Stay on the Waiver:							199

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Short-Term Respite Total:							759915.00
Short-Term Respite	<input type="checkbox"/>	15 minute	433	450.00	3.90	759915.00	
Youth Support and Training Total:							11010251.06
Group	<input type="checkbox"/>	15 minute	676	36.00	3.23	78605.28	
Individual	<input type="checkbox"/>	15 minute	3499	242.00	12.91	10931645.78	
GRAND TOTAL:							20998873.84
Total: Services included in capitation:							
Total: Services not included in capitation:							20998873.84
Total Estimated Unduplicated Participants:							4600
Factor D (Divide total by number of participants):							4564.97
Services included in capitation:							
Services not included in capitation:							4564.97
Average Length of Stay on the Waiver:							199

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 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 5

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Living/Skills Building Total:							2478028.80
Independent Living/Skills Building	<input type="checkbox"/>	15 minute	1088	292.00	7.80	2478028.80	
Parent Support and Training Total:							7105240.82
Group	<input type="checkbox"/>	15 minute	594	28.00	3.23	53721.36	
Individual	<input type="checkbox"/>	15 minute	3457	158.00	12.91	7051519.46	
Short-Term Respite Total:							788622.90
							788622.90
GRAND TOTAL:							21793059.35
Total: Services included in capitation:							
Total: Services not included in capitation:							21793059.35
Total Estimated Unduplicated Participants:							4600
Factor D (Divide total by number of participants):							4737.62
Services included in capitation:							
Services not included in capitation:							4737.62
Average Length of Stay on the Waiver:							199

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Short-Term Respite	<input type="checkbox"/>	15 minute	433	467.00	3.90		
Youth Support and Training Total:							11421166.83
Group	<input type="checkbox"/>	15 minute	676	38.00	3.23	82972.24	
Individual	<input type="checkbox"/>	15 minute	3499	251.00	12.91	11338194.59	
GRAND TOTAL:							21793059.35
Total: Services included in capitation:							21793059.35
Total: Services not included in capitation:							4600
Total Estimated Unduplicated Participants:							4737.62
Factor D (Divide total by number of participants):							
Services included in capitation:							4737.62
Services not included in capitation:							
Average Length of Stay on the Waiver:							199