

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:

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

C. Waiver Number: LA.0889

D. Amendment Number: LA.0889.R00.05

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

12/01/15

Approved Effective Date of Waiver being Amended: 03/01/12

2. Purpose(s) of Amendment

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

The purpose of the amendment is to:

- Update the brief waiver description
- Update performance measures to align with federal assurances/sub-assurances
- Remove the Crisis Stabilization service from the waiver. Crisis Stabilization will be added to the State Plan in an upcoming amendment.
- Replace the provision of waiver services at least monthly with monthly monitoring of the individual when services are furnished on a less than monthly basis.
- Update Eligibility Groups served in the waiver.
- Update the public input process (Main, 6- I)
- Update Main/Attachment #2 and Appendix C-5 regarding Home and Community-Based Settings,

3. Nature of the Amendment

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

| Component of the Approved Waiver | Subsection(s) |
|----------------------------------|---------------|
| | |

| Component of the Approved Waiver | Subsection(s) |
|---|---------------|
| <input checked="" type="checkbox"/> Waiver Application | |
| <input checked="" type="checkbox"/> Appendix A – Waiver Administration and Operation | |
| <input checked="" type="checkbox"/> Appendix B – Participant Access and Eligibility | |
| <input checked="" type="checkbox"/> Appendix C – Participant Services | |
| <input checked="" type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery | |
| <input type="checkbox"/> Appendix E – Participant Direction of Services | |
| <input type="checkbox"/> Appendix F – Participant Rights | |
| <input checked="" type="checkbox"/> Appendix G – Participant Safeguards | |
| <input checked="" type="checkbox"/> Appendix H | |
| <input checked="" type="checkbox"/> Appendix I – Financial Accountability | |
| <input checked="" type="checkbox"/> Appendix J – Cost-Neutrality Demonstration | |

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

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

Specify:

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

1. Request Information (1 of 3)

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

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

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

C. Type of Request: amendment

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

- 3 years 5 years

Waiver Number: LA.0889.R00.05

Draft ID: LA.029.00.06

D. Type of Waiver (select only one):

Regular Waiver ▼

E. Proposed Effective Date of Waiver being Amended: 03/01/12

Approved Effective Date of Waiver being Amended: 03/01/12

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 Behavioral Health Services Waiver, approved by CMS effective 3/1/12.

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 statewide requirements in §1902(a)(1) of the Act (*select one*):
- No
- Yes

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

- Geographic Limitation.** A waiver of statewide 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 statewide 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 6-1 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 newspaper 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.

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:

Owen

First Name:

Lou Ann

Title:

Deputy Medicaid Director

Agency:

Department of Health and Hospitals

Address:

628 N. 4th Street

Address 2:

City:

Baton Rouge

State:

Louisiana

Zip:

70821-9030

Phone:

(225) 342-1353

Ext:

TTY

Fax:

(225) 342-9508

E-mail:

LouAnn.Owen@LA..GOV

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

Last Name:

| | | |
|-------------|-----------------------------|--|
| First Name: | Stubbs | |
| Title: | Karen | |
| Agency: | Deputy Assistant Secretary | |
| Address: | Office of Behavioral Health | |
| Address 2: | 628 N. 4th Street | |
| City: | | |
| State: | Baton Rouge | |
| Zip: | Louisiana | |
| Phone: | (225) 342-1435 | Ext: <input type="text"/> <input type="checkbox"/> TTY |
| Fax: | (225) 342-5066 | |
| E-mail: | Karen.Stubbs@LA.GOV | |

8. Authorizing Signature

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

| | |
|------------------|-------------------------------------|
| Signature: | Jeanne Levelle |
| | State Medicaid Director or Designee |
| Submission Date: | Aug 13, 2015 |

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

| | |
|-------------|---------|
| Last Name: | Kennedy |
| First Name: | Ruth |
| Title: | |

| | | | |
|------------|-------------------------------------|-----------|---|
| Agency: | Medicaid Director | | |
| Address: | Bureau of Health Services Financing | | |
| Address 2: | 628 North 4th Street | | |
| City: | 7th Floor | | |
| State: | Baton Rouge | Louisiana | |
| Zip: | 70802 | | |
| Phone: | (225) 342-9240 | Ext: | <input type="text"/> <input type="checkbox"/> TTY |
| Fax: | (225) 342-9508 | | |
| E-mail: | Ruth.Kennedy@la.gov | | |

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 will be added to the State Plan in an upcoming amendment in order to expand the service.

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 HCBS 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

The Statewide Transition Plan submitted to CMS on March 17, 2015, provides an in-depth review of the Settings Rule and includes detailed information about public input, assessment and review, and remediation efforts. OBH invites reviewers to seek greater details about the OBH plan and how it relates to the Statewide Transition Plan.

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.

B) Assessment and Review:

A provider self-assessment instrument was 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.

With the move towards integration of physical and behavioral health services and since we're under a temporary, emergency contract with a Statewide Management Organization which is slated to end November 30th, OBH plans to assess CSoc provider's adherence to the HCBS setting rule beginning December 1, 2015 using questions outlined in the provider self-assessment tool as part of the credentialing and re-credentialing process. In addition, OBH will ensure members reside in home and community-based settings on no less than a quarterly basis through participant interviews conducted by Wraparound Facilitators.

Analysis of findings is scheduled to begin January 1, 2016 and continue through the month of March. The findings will be posted by May 1, 2016 and a final report will be submitted to CMS by June 1, 2016.

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. Each Office will conduct an on-site review to evaluate the validity of remediation compliance. An appeal process, to be developed, will allow the provider to dispute the HCB Setting's compliance. A disenrollment process of non-compliant providers will be developed and consist of: 1) provider disenrollment as a 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 will assess provider compliance through reports, interviews and on-site inspections that will gather information from providers and individuals receiving services. Participant surveys will ask questions whose specific object is that of obtaining the individual's perception of the Settings Rule. Progress on completion of this Statewide Transition Plan will be monitored at least every three months and will include public posting on the status of the Plan to facilitate public input. Stakeholder engagement and sharing public information will continue through the implementation of the Plan, with the following benchmarks appearing on the website: 1) final copies of the residential and non-residential assessment documents; 2) final copy of the participant survey; and 3) a copy of the Master Plan, updated as needed. Each Office will issue a final report to CMS in March, 2019.

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 and Hospitals (DHH) 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 DHH. Within DHH, 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 waivers, BHSF created the Medicaid Program Support and Waivers (MPSW) Section to oversee the administration of all Louisiana Medicaid waiver programs. Monitoring is completed under the direction of the MPSW Section Chief. The MPSW Section, through performance measures listed in the Quality Improvement Strategy (QIS) and systems described in Appendix H, ensures that OBH performs its assigned waiver operational functions in accordance with this document. OBH formally submits performance measure data, analysis and remediation actions to MPSW quarterly as described in the QIS.

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. The MOU requires BHSF and OBH to:

- Meet at least quarterly with the Division of Health Economics to review the financial accountability reports for the waiver program
- Meet and review rules and waiver amendments drafted by OBH prior to any rule making or changes to existing rules and waivers.

Meetings are held routinely to identify programmatic issues and communicate resolutions through the following committees:

1. DHH 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 MPSW
2. BHSF/Program Offices Executive Committee – meets at least quarterly to discuss problems, issues, planning, and concerns regarding waivers. Members include representatives from MPSW, the Medicaid Director or Deputy Director, the OBH Assistant Secretary, and other designated staff
3. Medicaid Quality Committee – meets at least quarterly to address common performance expectations applicable to the PIHP and Medicaid fee-for-service. Membership includes upper level administration and Section Chiefs/Division Directors from OBH, Office of Aging and Adult Services (OAAS), and Office for Citizens with Developmental Disabilities (OCDD), MPSW, and the Medicaid Quality Management, Statistics, and Reporting (QMSR) section.

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 –The variance committee meets quarterly to manage waiver enrollment 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.
3. Waiver expenditures managed against approved levels– OBH is responsible for completing the annual CMS-372 report utilizing MMIS data and submitting it to BHSF for review and approval. 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. OBH formally submits performance measure data, analysis and remediation actions to MPSW as described in the Appendix B QIS.
5. Review participant service plans- OBH is responsible for submitting aggregated reports on plan of care assurances to BHSF on an established basis. OBH formally submits performance measure data, analysis and remediation actions to MPSW as specified in Appendix D. In addition, the PIHP submits reports to BHSF on the number of service plans updated/revised at least annually.
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 MPSW 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 MPSW as specified in Appendix D: QIS sub-assurance d.

8. Qualified provider enrollment - DHH is requiring that the PIHP contract with all current licensed and enrolled waiver providers for at least the first year of the concurrent 1915 (b)(c) waiver. This is intended to promote continuity of care and choice of providers. In addition, the PIHP may contract with any other licensed home and community based service provider even if not previously enrolled in Medicaid. 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 MPSW 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. The PIHP may pay higher rates as they deem necessary or appropriate, but may not pay less than the minimum set by BHSF/OBH.

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, as well as communication distribution via OBH Help Lines regarding waiver eligibility and policy administration.

11. Quality assurance and quality improvement activities - To ensure compliance with federal regulations governing waivers, BHSF created the Medicaid Program Support and Waivers (MPSW) Section to oversee the administration of all Louisiana Medicaid waiver programs. Monitoring is completed under the direction of the MPSW Section Chief. The MPSW Section, through performance measures listed in the Quality Improvement Strategy (QIS), and systems described in Appendix H, ensures that 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 MPSW 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:

Enrollment Broker:

Submits monthly reports to BHSF and OBH of tracking volume and timelines for contract activities and deliverables. The report includes PIHP enrollments made, period of time between waiver eligibility determination and PIHP enrollment, and other summary statistics as required. BHSF and OBH will perform on-going monitoring of the enrollment broker's activities and adherence to the terms of the contract.

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. Retrospective review of case management assessments and Plans of Care will occur on an annual basis through a monitoring review process performed by OBH staff. The monitoring process includes a representative sample record review with face-to-face participant interviews utilizing performance measures described in the Service Plan and Health & Welfare Quality Improvement Strategies. The results of this monitoring will be entered into a Monitoring Database which will generate aggregate reports annually by waiver population and by the PIHP. The PIHP submits to BHSF and OBH monthly case management reports which indicate the time between the PIHP enrollment and service delivery, verification of service delivery in accordance with the POC, and other summary statistics as required. BHSF and OBH will perform on-going monitoring of the PIHP's activities and adherence to the terms of the contract.

DHH 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.

DHH will maintain a Critical Incident Reporting (CIR) and Management System and require the PIHP to enter and

track incidents within the system. The PIHP will be required to develop and implement CIR policies and procedures, subject to OBH approval, that are consistent with all requirements listed in this waiver document. OBH quality staff will generate reports at least quarterly to monitor PIHP compliance as outlined in Appendix G.

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"/> |
| 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.I. Number and percentage of performance measure reports which were received on time and complete with operating agency analysis and remediation activities.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

| | |
|---|--|
| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
| <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"/> |

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:

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

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 type="checkbox"/> Quarterly | <input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/> |
| <input type="checkbox"/> Other Specify: <input type="text"/> | <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 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"/> |

Performance Measure:

A.a.i.4: Number and percentage of implemented QIPs that were effective as evidenced by meeting the 86% threshold upon the subsequent monitoring cycle.

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 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 type="checkbox"/> Other Specify: <input type="text"/> | <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"/> | |

| | | |
|--|----------------------|--|
| | <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 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"/> |

Performance Measure:

A.a.i.5: Number and percentage of providers that did not meet the 2014 HCBS Settings Rule and have submitted an approved Corrective Action Plan for compliance.

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 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="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.6: Number and percentage of providers that did not meet the 2014 HCBS Settings Rule and implemented the approved Corrective Action Plan for compliance.

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 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.

The Medicaid Program Support and Waivers (MPSW) Section employs continuous collaboration and communication with OBH’s key personnel and committees to address performance measure non-compliance, both on an individual basis and systemic basis.

When reports are not submitted timely, MPSW works with OBH to determine the cause(s) and collaborates to identify solutions to prevent future occurrences.

Through report submission and leadership of the Medicaid Quality Committee, MPSW monitors quarterly and annual performance measure data and QIP status reports to ensure that appropriate, effective, and timely corrective action is taken by OBH to address non-compliance issues. When MPSW determines that OBH is not fulfilling its remediation responsibilities, MPSW notifies the program office key personnel, including the assistant secretary and informs them of the specific expectations to address the issues. MPSW continuously monitors OBH’s progress in completing required remediation activities and documentation. MPSW institutes various activities such as technical assistance, staff training, clarifying/revising policy, and routine meetings to ensure that appropriate and effective actions are taken to correct problems and/or make improvements.

ii. Remediation Data Aggregation

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

| Responsible Party (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
|---|---|
| <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"/> |

c. Timelines

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

- No
- Yes

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

Appendix B: Participant Access and Eligibility

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

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

| Target Group | Included | Target SubGroup | Minimum Age | Maximum Age | |
|---|--------------------------|----------------------|-------------|-------------------|--------------------------|
| | | | | Maximum Age Limit | No Maximum Age Limit |
| <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 | | | | | |

| Target Group | Included | Target SubGroup | Minimum Age | Maximum Age | |
|--|-------------------------------------|-------------------------------|-------------|-------------------|--------------------------|
| | | | | Maximum Age Limit | No Maximum Age Limit |
| | <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 | 21 | |
| | <input checked="" type="checkbox"/> | Serious Emotional Disturbance | 0 | 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 youth approaches the age of 22 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 OBH staff or its designee 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 youth as he/she approaches age 22. One strategy in the transition planning process will be a referral to OBH or its designee to determine eligibility for adult community based services and mental health supports. If the youth 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 | 1200 |
| Year 2 | 1200 |
| Year 3 | 2400 |
| Year 4 | 2400 |
| Year 5 | 2400 |

- 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 | <input type="text"/> |
| Year 2 | <input type="text"/> |
| Year 3 | <input type="text"/> |
| Year 4 | <input type="text"/> |
| Year 5 | <input type="text"/> |

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: 03/01/12

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: 1200

| Month | Base Number of Participants | Change | Participant Limit |
|-------|-----------------------------|--------|-------------------|
| Mar | 1200 | 0 | 1200 |
| Apr | 1200 | 0 | 1200 |
| May | 1200 | 0 | 1200 |
| Jun | 1200 | 0 | 1200 |
| 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 |

Waiver Year 2
Unduplicated Number of Participants: 1200

| Month | Base Number of Participants | Change | Participant Limit |
|-------|-----------------------------|--------|-------------------|
| Mar | 1200 | 0 | 1200 |
| Apr | 1200 | 0 | 1200 |
| May | 1200 | 0 | 1200 |
| Jun | 1200 | 0 | 1200 |
| 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 |

Waiver Year 3
Unduplicated Number of Participants: 2400

| Month | Base Number of Participants | Change | Participant Limit |
|-------|-----------------------------|--------|-------------------|
| Mar | 1200 | 480 | 1680 |
| Apr | 1680 | 240 | 1920 |
| May | 1920 | 240 | 2160 |
| Jun | 2160 | 240 | 2400 |
| Jul | 2400 | 0 | 2400 |
| Aug | 2400 | 0 | 2400 |
| Sep | 2400 | | 2400 |

Waiver Year 4
Unduplicated Number of Participants: 2400

| Month | Base Number of Participants | Change | Participant Limit |
|-------|-----------------------------|--------|-------------------|
| Mar | 2400 | 0 | 2400 |
| Apr | 2400 | 0 | 2400 |
| May | 2400 | 0 | 2400 |
| Jun | 2400 | 0 | 2400 |
| Jul | 2400 | 0 | 2400 |
| Aug | 2400 | 0 | 2400 |
| Sep | 2400 | 0 | 2400 |

Phase-In/Phase-Out Schedule

| Month | Base Number of Participants | Change | Participant Limit |
|-------|-----------------------------|--------|-------------------|
| | | 0 | |
| Oct | 2400 | 0 | 2400 |
| Nov | 2400 | 0 | 2400 |
| Dec | 2400 | 0 | 2400 |
| Jan | 2400 | 0 | 2400 |
| Feb | 2400 | 0 | 2400 |

| Month | Base Number of Participants | Change | Participant Limit |
|-------|-----------------------------|--------|-------------------|
| Oct | 2400 | 0 | 2400 |
| Nov | 2400 | 0 | 2400 |
| Dec | 2400 | 0 | 2400 |
| Jan | 2400 | 0 | 2400 |
| Feb | 2400 | 0 | 2400 |

Waiver Year 5

Unduplicated Number of Participants: 2400

| Month | Base Number of Participants | Change | Participant Limit |
|-------|-----------------------------|--------|-------------------|
| Mar | 2400 | 0 | 2400 |
| Apr | 2400 | 0 | 2400 |
| May | 2400 | 0 | 2400 |
| Jun | 2400 | 0 | 2400 |
| 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 |

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 | Mar | |
| Phase-in/Phase-out begins | Mar | 3 |
| Phase-in/Phase-out ends | Jun | 3 |

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

I. 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)
- Qualified pregnant women and children (1902(a)(10)(A)(i)(III), (IV), (VI), and (VII))
- Foster Care and adoption subsidy (42 CFR 435.115(e)(1) and (2); 435.145; 435.222; 435.227)
- Children eligible under the Chaffee Foster Care Independence Act of 1999 1902(a)(10)(A)(ii)(XVII) and 1905 (w)

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.

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 (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-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 (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).

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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:

Wraparound Agencies

- 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 for or a decision regarding changes in level of care is required.

The CANS Comprehensive Multisystem Assessment is completed based on a face-to-care interview with the child (and parent(s) when possible) and additional supporting information. 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 0 and through the age of 21 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: Number and percent of initial participants who meet the level of care requirements prior to receipt of services

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 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"/> <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 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: Number and percent of participants whose level of care determination form was completed timely, as required by the State

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 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 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: Number and percent of initial participants whose level of care determination forms/instruments were completed correctly

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 = +,-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 Source (Select one):

Other

If 'Other' is selected, specify:

PIHP record review validation

| 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 checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly | <input checked="" 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 checked="" type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: <input type="text"/> |
| | <input type="checkbox"/> Continuously and Ongoing | <input checked="" type="checkbox"/> Other Specify: Random sample of at least 30 records based on NCQA medical record review auditing standards |
| | <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"/> |

Performance Measure:

LOC4: Number and percent of participants whose level of care determination was made by a qualified evaluator

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 = +,-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 Source (Select one):
Other
 If 'Other' is selected, specify:
PIHP record review validation

| 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 checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly | <input checked="" 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 | <input checked="" type="checkbox"/> Annually | <input type="checkbox"/> Stratified |

| | | |
|----------------------------------|---|---|
| Specify: <input type="text"/> | | Describe Group: <input type="text"/> |
| | <input type="checkbox"/> Continuously and Ongoing | <input checked="" type="checkbox"/> Other Specify: Random sample of at least 30 records based on NCQA medical record review auditing standards |
| | <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"/> |

- 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.