Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of the Secretary

VIA ELECTRONIC MAIL ONLY

August 27, 2014

Bill Brooks
Associate Regional Administrator
Division of Medicaid & Children's Health
DHHS/Centers for Medicare and Medicaid Services
1301 Young Street, Room #833
Dallas, Texas 75202

Dear Mr. Brooks:

RE: Louisiana Title XIX State Plan
Transmittal No. 14-33

I have reviewed and approved the enclosed Louisiana Title XIX State Plan material. I recommend this material for adoption and inclusion in the body of the State Plan.

Sincerely,

Kathy H. Kliebert
Secretary

Approved for

Attachments (1)

KHK/JRK/DAB

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **14-33**

2. STATE: **Louisiana**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **March 1, 2015**

5. TYPE OF PLAN MATERIAL *(Check One)*:

G NEW STATE PLAN G AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1915(i) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY **2015** **$0.00**
b. FFY **2016** **$0.00**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-G, Pages 1-28
Attachment 3.1-G, Page 29
Attachment 3.1-G, Page 30
Attachment 3.1-G, Page 31
Attachment 3.1-G, Page 32
Attachment 3.1-G, Page 33
Attachment 3.1-G, Page 34
Attachment 3.1-G, Page 35-37

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Same (TN 11-13)
Same (TN 11-13)-replace page 29 & remove page 30
Same (TN 11-13)-remove old pages 31 & 32
Same (TN 11-13)-remove old pages 33 & 34
Same (TN 11-13)-remove old page 35
Same (TN 11-13)-remove old page 36
Same (TN 11-13)-replaces page 37, removes 38-42
Same (TN 13-38)-replaces pages 43, 43a & 44

10. SUBJECT OF AMENDMENT: **The purpose of this SPA is to amend the provisions governing 1915(i) Behavioral Health services in order to make programmatic and technical changes to the State Plan.**

11. GOVERNOR=S REVIEW *(Check One)*:
G GOVERNOR=S OFFICE REPORTED NO COMMENT
G COMMENTS OF GOVERNOR=S OFFICE ENCLOSED
G NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor does not review state plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Kathy H. Kliebert

14. TITLE:
Secretary

15. DATE SUBMITTED:
August 27, 2014

16. RETURN TO:

J. Ruth Kennedy, Medicaid Director
State of Louisiana
Department of Health and Hospitals
628 N. 4th Street
PO Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS: **The revisions in boxes 8 and 9 represent a complete replacement of Attachment 3.1-G.**

FORM HCFA-179 (07-92)

1915(i) State plan Home and Community-Based Services Administration and Operation

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. Services. *(Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Adult Behavioral Health Services concurrent with the Behavioral Health 1915(b) waiver under a capitated reimbursement methodology

2. Statewideness. *(Select one)*:

●	The State implements the 1915(i) State plan HCBS benefit statewide, per §1902(a)(1) of the Act.
○	The State implements this benefit without regard to the statewideness requirements in §1902(a)(1) of the Act. State plan HCBS will only be available to individuals who reside in the following geographic areas or political subdivisions of the State. *(Specify the areas to which this option applies)*:

3 State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

●	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	○	The Medical Assistance Unit *(name of unit)*:	
	●	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	Office of Behavioral Health (OBH) within Department of Health and Hospitals (DHH)
○	The State plan HCBS benefit is operated by *(name of agency)*		
	a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

4. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the State assures that):* When the Medicaid agency does not directly conduct an administrative 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. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☑	☑	☐
2 State plan HCBS enrollment managed against approved limits, if any	☑	☑	☑	☐
3 Eligibility evaluation	☑	☑	☑	☐
4 Review of participant service plans	☑	☑	☑	☐
5 Prior authorization of State plan HCBS	☑	☑	☑	☐
6 Utilization management	☑	☑	☑	☐
7 Qualified provider enrollment	☑	☑	☑	☐
8 Execution of Medicaid provider agreement	☑	☑	☑	☐
9 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☑	☑	☐
11 Quality assurance and quality improvement activities	☑	☑	☑	☐

1. Information for potential enrollees will be disseminated by the contracted risk-based managed cared entity which operates under a concurrent 1915(b) waiver authority for adults. In addition, the operating agency, and/or the Medicaid may disseminate information.

2. State Plan HCBS enrollment against approved limits, if any. There are no limits under the 1915(i) State Plan. Enrollment will be tracked by the managed care entity, operating agency, and Medicaid agency.

3. DHH makes the final 1915(i) enrollment eligibility decisions. Eligibility determinations including financial eligibility reviews for Medicaid will be performed by Medicaid eligibility staff. Subject to the final enrollment determination of DHH, targeting and clinical needs-based criteria assessments will be performed by the managed care entity pursuant to policies and procedures set up and approved in advance. The managed care entity and the individuals performing the assessments are not 1915(i) providers. The managed care entity clinical needs-based assessments will be reviewed pursuant to the 1915(i) QIS requirements listed later in this State Plan by DHH staff.

4. Review of participant treatment plans will be conducted by the managed care entity pursuant to policies and procedures set up and subject to the approval of operating agency and Medicaid.

5. Prior authorization of State Plan HCBS will be conducted by the managed care entity pursuant to policies and procedures set up and subject to the approval of the operating agency and Medicaid.

6. Utilization management will be conducted by the managed care entity pursuant to policies and procedures set up and subject to the approval of the operating agency and Medicaid.

7. Qualified provider enrollment and recruitment will be conducted by the managed care entity pursuant to policies and procedures set up and subject to the approval of the operating agency and Medicaid.

8. Execution of Medicaid provider agreements with HCBS providers will be conducted by the managed care entity. Execution of the managed care entity contract will be with the operating agency with oversight from Medicaid.

9. Establishment of a consistent rate methodology for each State plan HCBS is by the Medicaid agency.

10. Rules, policies, procedures and information development governing the State plan HCBS benefit – Rules are promulgated by the Medicaid agency. Policies, procedures and information will be generally outlined in the managed care entity contract by the operating agency. The managed care entity will develop formal provider manuals, billing guidelines and information subject to the operating agency agreement.

11. Quality assurance and quality improvement activities are conducted by the managed care entity pursuant to policies and procedures set up and subject to the approval of the operating agency and Medicaid and pursuant to the State's Quality Improvement Strategy.

(By checking the following boxes the State assures that):

5. ☑ **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

DHH makes the final 1915(i) enrollment eligibility decisions. Subject to the approval of the operating agency and Medicaid, targeting and clinical needs-based criteria assessments will be performed by the managed care entity pursuant to policies and procedures set up and approved in advance. The managed care entity and the individuals performing the assessments are not 1915(i) providers and that assessment units are administratively separate from utilization review units and functions. The managed care entity clinical needs-based assessments will be reviewed pursuant to the 1915(i) QIS requirements listed later in this State Plan by DHH staff.

In addition, the managed care entity will conduct reviews of all individuals completing assessments and plans of care to ensure that they are not 1915(i) providers or are employed by a provider who is on the plan of care. The managed care entity will utilize authority under treatment planning per 42 CFR 438.208(c) to identify, assess and develop treatment plans for individuals with special health care needs as defined under this 1915(i) authority.

In particular the following conflict mitigation strategies will be utilized by the operating agency:

- Assuring that individuals can advocate for themselves or have an advocate present in planning meetings.
- Documenting that the individual has been offered choice among all qualified providers of direct services.
- Establishing a member advisory council within the organization to monitor issues of choice.
- Establishing clear, well-known, and easily accessible means for members to make grievances and/or appeals to the State for assistance regarding concerns about choice, quality, and outcomes.
- Documenting the number and types of appeals and the decisions regarding grievances and/or appeals.
- Having State quality management staff oversee the managed care entity to assure member choice and control are not compromised.
- Documenting member experiences with measures that capture the quality of plan of care development.

6. ☑ **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E. *Enrollees will exhaust the PIHP appeals process as outlined in 1915(b) per 42 CFR 438 subpart F.*

7. ☑ **No FFP for Room and Board.** The State has methodology to prevent claims for Federal Financial Participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Target Group(s)

☑ **Target Group(s).** The State elects to target this 1915(i) State Plan HCBS benefit to a specific population. With this election, the State will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the State may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C). *(Specify target group(s)):*

An Adult over the age of 18 who meets one of the following criteria is eligible to receive State Plan HCBS services:

Persons with ACUTE Stabilization Needs – The person with AS needs currently presents with Mental health symptoms that are consistent with a diagnosable mental disorder specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) or the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), or subsequent revisions of these documents.

- Persons with SMI (federal SAMHSA definition of Serious Mental Illness as of 12/1/2011) – The person with SMI has at least one diagnosable mental disorder, which is commonly associated with higher levels of impairment. These diagnoses, per the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) or the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), include only:

Schizophrenia Spectrum and Other Psychotic Disorders
Schizophrenia
Schizoaffective Disorder
Delusional Disorder Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

Bipolar and Related Disorders
Bipolar I Disorder
Bipolar II Disorder
Other Specified Bipolar and Related Disorder
Unspecified Bipolar and Related Disorder

Depressive Disorders
Major Depressive Disorder

- Persons with MMD(Major Mental Disorder)
- An adult who has previously met the above criteria and needs subsequent medically necessary services for stabilization and maintenance.

Note: Individuals eligible for EPSDT will receive these services through the EPSDT State Plan and not under the 1915(i).

Exclusion: Diagnosis of a substance use disorder without an additional co-occurring Axis I disorder.

Because this 1915(i) State Plan Amendment specifically targets psychosocial services to individuals with mental Illness, Louisiana is requesting five year approval of the State Plan amendment for comparability and targeting. Prior to January 1, 2017, Louisiana will renew its targeted population via a 1915(i) State Plan Renewal for an additional five year period after documenting that federal requirements are met.[1]

[1]The August 6, 2010 SMD letter says that five year renewal only applies if a state targets services and populations: "If a State chooses to implement this option to provide State plan HCBS to a targeted population (s), the ACA authorizes CMS to approve such a SPA for a five year period. States will be able to renew approved 1915(i) services for additional five year periods if CMS determines, prior to the beginning of the renewal period, that the State met Federal and State requirements and that the State's monitoring is in accordance with the Quality Improvement Strategy specified in the State's approved SPA."

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants in the Medicaid 1915(i) category	Projected Number of Participants for 1915(i) only category	Total Number of Projected Participants
Year 1	3/1/2012	2/28/2013	25,884	56	25,940
Year 2	3/1/2013	2/28/2014	27,178	59	27,237
Year 3	3/1/2014	2/28/2015	28,537	62	28,599
Year 4	3/1/2015	2/28/2016	29,964	65	30,029
Year 5	3/1/2016	2/28/2017	31,462	68	31,530

2. ☑ **Annual Reporting.** *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Income Limits.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are in an eligibility group covered under the State's Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). Individuals with incomes up to 150% of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services may be eligible to receive services under 1915(i) provided they meet all other requirements of the 1915(i) State plan option. The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

2. Medically Needy. *(Select one):*

○	The State does not provide State plan HCBS to the medically needy.	
●	The State provides State plan HCBS to the medically needy *(select one):*	
	●	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. **Once the individual has been determined to be eligible as medically needy using institutional rules, and has been determined to meet the 150% FPL limit, the individual would only be eligible for State Plan HCBS under section 1915(i) of the Act. However, individuals who are eligible for Medicaid as medically needy under income and resource rules applicable in the community, and whose income does not exceed the 150% limit, would be eligible for State Plan HCBS, as well as, all Medicaid State Plan services.**
	○	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

3. Presumptive Eligibility. The State, at its option, elects to provide for a period of presumptive eligibility (not to exceed a period of 60 days) only for those individuals that the State has reason to believe may be eligible for home and community-based services. Such presumptive eligibility shall be limited to medical assistance for carrying out the independent evaluation and assessment to determine an individual's eligibility for such services and if the individual is so eligible, the specific home and community-based services that the individual will receive.

Needs-Based Evaluation/Reevaluation

1. Responsibility for Performing Evaluations / Reevaluations. Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual. Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*select one*):

○	Directly by the Medicaid agency
●	By Other (*specify State agency or entity with contract with the State Medicaid agency*):

	The operating agency will make the final waiver enrollment determination based on information collected from the managed care entity.

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The individuals performing evaluations must be an individual trained to administer the targeting and needs-based criteria evaluation. The individual must be a certified LOCUS screener. These individuals may be:

- a licensed practitioner of the healing arts – or –

- LMHP including the following:
  - Physician
  - 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)

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The evaluation and reevaluation must use the targeting and needs-based assessment criteria outlined in the 1915(i) SPA and LOCUS assessment tool and qualified personnel. This is the same process used to both evaluate and reevaluate whether an individual is eligible for the 1915(i) services.

4. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

Needs-based Criteria (Must meet one or more of the following criteria or has previously met the above criteria and needs subsequent medically necessary services for stabilization and maintenance)

***The needs based criteria is measured objectively (described more fully below) through the use of the LOCUS.**

1. The person is experiencing at least "moderate" levels of risk to self or others as evidenced by at least a score of 3 and no more than a score of 4 on the LOCUS Risk of Harm subscale and/or serious or severe levels of functional impairment as evidenced by at least a score of 4 on the LOCUS Functional Status subscale. This rating is made based on ***current*** manifestation and not past history.
2. The person experiences at least "moderate" levels of need as indicated by AT LEAST a composite LOCUS total score of 14 to 16, indicative of a Level of Care of 2 (aka, Low Intensity Community Based Services).
3. The person is experiencing "moderate" levels of need as indicated by AT LEAST a composite LOCUS total score of 17 to 19, indicative of at least a Level of Need of 3 (aka, High Intensity Community Based Service).

5. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

In practice, the hospital institutional criteria are approximately equivalent to a LOCUS score of 6 on the risk of harm subscale (compared to a 3 or 4 for the 1915(i)). The hospital cannot admit an individual for chronic needs (i.e., cannot admit for "Moderate" levels of need).

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
To receive 1915(i) services, the individual may either meet a risk of harm subscale of 3 or 4 for the 1915(i) or experience a "moderate" level of need as indicated by at least a composite LOCUS score of 14.	For initial and annual level of care assessments, Louisiana utilizes the Level of Care Eligibility Tool (LOCET) and/or the Minimum Data Set-Home Care (MDS-HC) to determine if an individual meets nursing	The level of care criteria is based upon the following: La. R.S. 28:451.2. Definitions: "...(12) Developmental Disability means either:	To be admitted to an inpatient psychiatric hospital, the individual must meet a risk of harm subscale of 6 (this corresponds to a composite LOCUS score higher than a 14). All individuals eligible for inpatient hospital admission

• The person is experiencing at least "moderate" levels of risk to self or others as evidenced by at least a score of 3 and no more than a score of 4 on the LOCUS Risk of Harm subscale and/or serious or severe levels of functional impairment as evidenced by at least a score of 4 on the LOCUS Functional Status subscale, This rating is made based on ***current*** manifestation and not past history. • The person experiences at least "moderate" levels of need as indicated by AT LEAST a composite LOCUS total score of 14 to 16, indicative of a Level of Care of 2 (aka, Low Intensity Community Based Services). • The person is experiencing "moderate" levels of need as indicated by AT LEAST a composite LOCUS total score of 17 to 19, indicative of at least a Level of Need of 3 (aka, High Intensity Community Based Services).	facility level of care and imminent risk criteria. LOCET is an objective and impartial tool, based upon the Minimum Data Set (MDS) Assessment® tool. The LOCET algorithm is designed to identify those individuals who meet the medical and functional necessity for admission to long term care programs in Louisiana. LOCET has seven distinct pathways of potential level of care eligibility. The seven pathways are: 1) activities of daily living; 2) cognitive function; 3) skilled rehabilitative services; 4) physician involvement; 5) behavior; 6) treatment and conditions; and 7) service dependency. The Minimum Data Set-Home Care (MDS-HC) is the screening component that enables a provider to assess multiple key domains of function, health, social support, and service use.	(a) A severe chronic disability of a person that: (i) Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments. (ii) Is manifested before the person reaches age twenty-two. (iii) Is likely to continue indefinitely. (iv) Results in substantial functional limitations in three or more of the following areas of major life activity: (aa) Self-care (bb) Receptive and expressive language. (cc) Learning. (dd) Mobility. (ee) Self-direction. (ff) Capacity for independent living. (gg) Economic self-sufficiency. (v) Is not attributed solely to mental illness. (vi) Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated. (b) A substantial developmental delay or specific congenital or acquired condition in a person from birth through age nine which, without services and support, has a high probability of resulting in those criteria in Subparagraph (a) of this Paragraph, later in life that may be considered to be a developmental disability." The Medicaid Bureau of Health Services Financing (BHSF) form 90-L is used to determine the ICF/DD Level of Care, which requires active treatment of a developmental disability under supervision of a qualified developmental disabilities professional. The individual's primary care physician must complete and sign and date the 90-L.	qualify for 1515(i) services because the criteria for 1915(i) is less stringent. Per R.S. 46: 153 adult admission criteria. The patient must meet one or more of 3 categories for Severity: 1. Patient presents a danger to self. 2. Patient presents as a danger to others due to a DSM-III-R Axis I diagnosis. 3. Patient is gravely disabled and unable to care for self due to a DSM-III-R Axis I diagnosis. The patient must meet all intensity of service criteria: 1. Ambulatory resources will not meet needs 2. Services in hospital are expected to improve condition or prevent further regression 3. Treatment of the condition requires inpatient services The patient does not have an exclusionary criteria: 1. Not medically stable 2. Patient with criminal charges with no DSM-III-R Axis 1 diagnosis 3. Person with anti-social behavior that is characterological 4. Persons with MR diagnosis without a DSM-III-R Axis 1 diagnosis

		This form must be completed at initial evaluation and annually thereafter to determine if the individual still meets the ICF/DD level of care. The 90-L is used in conjunction with the Statement of Approval (SOA) to establish a level of care criteria and to complete the Plan of Care. SOA is a notification to an individual who has requested waiver services that it has been determined by the OCDD Entry Unit that they meet the developmental disability criteria (Developmental Disability law-RES 28:451) for participation in programs administered by OCDD and that they have been placed on the Request for Services Registry for waiver services and their date of request. The 90-L, SOA and plan of care documents are submitted to the OCDD Regional Waiver Office for staff review to assure that the applicant/participant meets/continues to meet the level of care criteria.	

*Long Term Care/Chronic Care Hospital

(By checking the following boxes the State assures that):

6. ☑ **Reevaluation Schedule**. Needs-based eligibility reevaluations are conducted at least every twelve months.

7. ☑ **Adjustment Authority**. The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

8. ☑ **Residence in home or community**. The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State Plan HCBS:

(i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*

In all settings where individuals may receive HCBS State plan services, persons are encouraged and afforded the opportunity to exercise their options of when and where to take community outings, have freedom to choose roommates, and are free to exercise personal choices as are other persons who do not qualify for services under the 1915i SPA. Persons participating through PSH will have freedom to choose their services providers. Individuals will be encouraged to have control over their meal and sleep times, visitor access, privacy, room decorations, and ability to engage freely in the community. All the facilities are community based with a home-like environmental providing access to typical home facilities and integrated into the community.

This particular 1915(i) was written to support the Louisiana Permanent Supported Housing (PSH) program's goals. The PSH is by nature small, scattered site housing aimed at person-centered planning for individuals enjoying all aspects of the community. The settings that most individuals will reside will be PSH or other similar settings. These settings are home and community-based, integrated in the community, provide meaningful access to the community and community activities, and individuals have free choice of providers, individuals with whom to interact, and daily life activities.

No residences are IMDs or institutional in nature. Residencies must not be located in a building that is also a publicly or privately operated facility that provides institutional treatment or custodial care; and must not be located in a building on the grounds of, or immediately adjacent to, a public institution.

Person-Centered Planning & Service Delivery

(By checking the following boxes the State assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:

- An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;
- Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
- An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care;

- An examination of the individual's physical, addiction, and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
- If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
- A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.

2. ☑ Based on the independent assessment, the individualized plan of care:

- Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
- Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
- Prevents the provision of unnecessary or inappropriate care;
- Identifies the State plan HCBS that the individual is assessed to need;
- Includes any State plan HCBS in which the individual has the option to self-direct the purchase or control ;
- Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
- Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.

3. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

Educational/professional qualifications of individuals conducting assessments are a case manager who is a physician or an LMHP with a psychiatrist who must complete portions of the assessment. LMHPs include:

- 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).

4. Responsibility for Plan of Care Development. There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

Individualized, person-centered treatment plan will be developed by individuals with the following educational/professional qualifications: LMHP

5. **Supporting the Participant in Plan of Care Development**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the plan of care development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

(a) The treatment plan is developed by the participant and his or her interdisciplinary team based on information from the needs-based assessment, and taking into account the participant's social history, and treatment and service history. The case manager acts as an advocate for the participant in this process and is a source of information for the participant and the team. The participant and the team identify the participant's strengths, needs, preferences, desired outcomes, and his or her desires in order to determine the scope of services needed. The case manager informs the participant of all available Medicaid and non-Medicaid services. The participant is encouraged to choose goals based on his or her own desires while recognizing the need for supports to attain those goals.

(b)The interdisciplinary team includes the participant; his or her legal representative if applicable; the case manager; and any other persons the participant chooses, which may include service providers. Individuals that are not Medicaid providers are not reimbursed for their participation.

6. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from qualified providers of the 1915(i) services in the plan of care):*

The case manager informs the participant and his or her interdisciplinary team of all available qualified providers. This is part of the interdisciplinary team process when the treatment plan is developed, and again whenever it is renewed or revised. Participants are encouraged to meet with the available providers before choosing a provider.

7. **Process for Making Plan of Care Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

Louisiana will contract with a managed care entity to support certain Medicaid programs. The case manager requests authorization through the managed care entity, and managed care entity staff responsible for managing enrollment will respond. Case managers complete the assessment of the need for services and submit it to the managed care entity for evaluation of program eligibility. The case manager is also responsible for entering treatment plan information such as the services to be received, the effective dates, the amount of each service, and the selected provider into the online electronic medical record and care plan authorization forms maintained by the managed care entity. The operating agency will monitor the managed care entity's review and approval of the Plans of Care subject to Medicaid agency oversight.

8. **Maintenance of Plan of Care Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency	☐	Operating agency	☑	Case manager
☑	Other (*specify):*	The managed care entity will retain electronic copies of service plan.			

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title from the options for HCBS State plan services in Attachment 4.19-B):*	
Service Title:	**Psychosocial Rehabilitation Services**
Service Definition (Scope)*:*	

The following descriptions apply to all psychosocial rehabilitation provided by certified agencies or licensed clinics utilizing qualified practitioners. The psychosocial rehabilitation treatment provided includes the following:

- Treatment by a licensed mental health practitioner (LMHP) who is an individual licensed in the State of Louisiana to diagnose and treat mental illness or substance abuse disorder acting within the scope of all applicable state laws and their professional license.
- Community Psychiatric Support and Treatment (CPST)
- Psychosocial Rehabilitation (PR)
- Crisis Intervention (CI)

These psychosocial rehabilitation services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid eligible adults with significant functional impairments meeting the need levels in the 1915(i) resulting from an identified mental health or substance abuse disorder diagnosis. The medical necessity for these rehabilitative services must be determined by a licensed mental health practitioner or physician who is acting within the scope of his/her professional licensed and applicable state law and furnished by or under the direction of a licensed practitioner, to promote the maximum reduction of symptoms and/or restoration of a individual to his/her best age-appropriate functional level conducting an assessment consistent with state law, regulation and policy. A unit of service is defined according to the HCPCS approved code set unless otherwise specified.

<u>Definitions:</u>

The services are defined as follows:

1. Treatment by a licensed mental health practitioner (LMHP) who is an individual licensed in the State of Louisiana to diagnose and treat mental illness or substance abuse disorder acting within the scope of all applicable state laws and their professional license.

2. Community Psychiatric Support and Treatment (CPST) are goal directed supports and solution-focused interventions intended to achieve identified goal or objectives as set forth in the individual's individualized treatment plan. CPST is a face-to-face intervention with the individual present; however, family or other collaterals may also be involved. A minimum of 51% of CPST contacts must occur in community locations where the person lives, works, attends school, and/or socializes. This service may include the following components:
   A. Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.
   B. Individual supportive counseling, solution focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of assisting the individual with developing and implementing social, interpersonal, self-care, daily living and independent living skills to restore stability, to support functional gains, and to adapt to community living.

C. Participation in and utilization of strengths based planning and treatments which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness.
D. Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning.
E. Restoration, rehabilitation and support to develop skills to locate, rent and keep a home, landlord/tenant negotiations; selecting a roommate and renter's rights and responsibilities.
F. Assisting the individual to develop daily living skills specific to managing their own home including managing their money, medications, and using community resources and other self-care requirements.

3. Psychosocial Rehabilitation (PSR) services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's individualized treatment plan. The intent of psychosocial rehabilitation is to restore the fullest possible integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention. PR is a face-to-face intervention with the individual present. Services may be provided individually or in a group setting. A minimum of 51% of PR contacts must occur in community locations where the person lives, works, attends school, and/or socializes.
A. Restoration, rehabilitation and support with the development of social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop coping strategies, and effective functioning in the individual's social environment including home, work and school.
B. Restoration, rehabilitation and support with the development of daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily living. Supporting the individual with development and implementation of daily living skills and daily routines critical to remaining in home, school, work, and community.
C. Implementing learned skills so the person can remain in a natural community location.
D. Assisting the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.

4. Crisis Intervention (CI) services are provided to a person who is experiencing a psychiatric crisis, designed to interrupt and/or ameliorate a crisis experience including a preliminary assessment, immediate crisis resolution and de-escalation, and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. The goals of Crisis Interventions are symptom reduction, stabilization, and restoration to a previous level of functioning. All activities must occur within the context of a potential or actual psychiatric crisis. Crisis Intervention is a face-to-face intervention and can occur in a variety of locations, including an emergency room or clinic setting, in addition to other community locations where the person lives, works, attends school, and/or socializes.
A . A preliminary assessment of risk, mental status, and medical stability; and the need for further evaluation or other mental health services. Includes contact with the client, family members or other collateral sources (e.g. caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to other alternative mental health services at an appropriate level.
B. Short-term crisis interventions including crisis resolution and de-briefing with the identified Medicaid eligible individual.
C. Follow-up with the individual, and as necessary, with the individuals' caretaker and/or family members.
D. Consultation with a physician or with other qualified providers to assist with the individuals' specific crisis

Additional needs-based criteria for receiving the service, if applicable (specify):

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑ Categorically needy *(specify limits):*

LMHP limitations: Providers cannot provide services or supervision under this section if they are a provider who is excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. In addition, they may not be debarred, suspended, or otherwise excluded from participating in procurement activities under the State and Federal laws, regulations, and policies including the Federal Acquisition Regulation, Executive Order No.12549, and Executive Order No. 12549. In addition, providers who are an affiliate, as defined in the Federal Acquisition Regulation, of a person excluded, debarred, suspended or otherwise excluded under State and Federal laws, regulations, and policies may not participate. All services must be authorized. Services which exceed the limitation of the initial authorization must be approved for re-authorization prior to service delivery. In addition to licensure, service providers that offer addiction services must demonstrate competency as defined by the Department of Health and Hospitals, state law (ACT 803 of the Regular Legislative Session 2004) and regulations. Anyone providing addiction or behavioral health services must be certified by DHH, in addition to their scope of practice license. LMFTs and LACs are not permitted to diagnose under their scope of practice under state law. LPCs are limited by scope of practice under state law to diagnosing conditions or disorders requiring mental health counseling and may not use appraisal instruments, devices or procedures for the purpose of treatment planning, diagnosis, classification or description of mental and emotional disorders and disabilities, or of disorders of personality or behavior, which are outside the scope of personal problems, social concerns, educational progress and occupations and careers. Inpatient hospital visits are limited to those ordered by the individual's physician. Visits to nursing facility are allowed for psychologists if a PASRR (Preadmission Screening and Resident Review indicates it is medically necessary treatment. Social worker visits are included in the Nursing Visit and may not be billed separately. Visits to ICF-MR facilities are non-covered. All LMHP services provided while a person is a resident of an IMD such as a free standing psychiatric hospital or psychiatric residential treatment facility are content of the institutional service and not otherwise reimbursable by Medicaid. Evidence-based Practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by DHH.

CPST, PR, and CI Limitations: Services are subject to prior approval, must be medically necessary and must be recommended by a licensed mental health practitioner or physician according to an individualized treatment plan. The activities included in the service must be intended to achieve identified treatment plan goals or objectives. The treatment plan should be developed in a person-centered manner with the active participation of the individual, family and providers and be based on the individual's condition and the standards of practice for the provision of these specific rehabilitative services. The treatment plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The treatment plan must specify the frequency, amount and duration of services. The treatment plan must be signed by the licensed mental health practitioner or physician responsible for developing the plan. The plan will specify a timeline for reevaluation of the plan that is at least an annual redetermination. The reevaluation should involve the individual, family and providers and include a reevaluation of plan to determine whether services have contributed to meeting the stated goals. A new treatment plan should be developed if there is no measureable reduction of disability or restoration of functional level. The new plan should identify different rehabilitation strategy with revised goals and services. Anyone providing addiction or mental health services must be certified by DHH, in addition to any required scope of practice license required for the facility or agency to practice in the State of Louisiana. Providers must maintain case records that include a copy of the treatment plan, the name of the individual, dates of services provided, nature, content and units of rehabilitation services provided, and progress made toward functional improvement and goals in the treatment plan. Services provided at a work site must not be job tasks oriented. Any services or components of services the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, child care, and laundry services) are non-covered. Services cannot be provided in an institute for mental disease (IMD). Room and board is excluded from any rates provided in a residential setting. Evidence-based Practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by DHH. Services may be provided at a site-based facility, in the community or in the individual's place of residence as outlined in the Plan of Care. Components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual are not eligible for Medicaid reimbursement.

CPST Limitations: Caseload Size must be based on the needs of the clients/families with an emphasis on successful outcomes and individual satisfaction and must meet the needs identified in the individual treatment plan. The CPST provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a LMHP or PIHP-designated LMHP with experience regarding this specialized mental health service. All analysis of problem behaviors must be performed under the supervision of a licensed psychologist/medical psychologist.

	PR Limitations: Limit of 750 hours of group psychosocial rehabilitation per calendar year. This limit can be exceeded when medically necessary through prior authorization. The PR provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a LMHP or PIHP-designated LMHP with experience regarding this specialized mental health service. CI Limitations: All individuals who self-identify as experiencing a seriously acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it are eligible. An individual in crisis may be represented by a family member or other collateral contact who has knowledge of the individual's capabilities and functioning. Individuals in crisis who require this service may be using substances during the crisis**.** Substance use should be recognized and addressed in an integrated fashion as it may add to the risk increasing the need for engagement in care. The assessment of risk, mental status, and medical stability must be completed by a LMHP or PIHP-designated LMHP with experience regarding this specialized mental health service, practicing within the scope of their professional license. The crisis plan developed from this assessment and all services delivered during a crisis must be provided under the supervision of a LMHP or PIHP-designated LMHP with experience regarding this specialized mental health service, and such must be available at all times to provide back up, support, and/or consultation. Crisis services cannot be denied based upon substance use. The Crisis Intervention specialist must receive regularly scheduled clinical supervision from a person meeting the qualifications of a LMHP or PIHP-designated LMHP with experience regarding this specialized mental health service. Crisis Intervention – Emergent is limited to 6 hours per episode. Crisis Intervention – Ongoing is limited to 66 hours per episode. An episode is defined as the initial face to face contact with the individual until the current crisis is resolved, not to exceed 14 days. The individual's chart must reflect resolution of the crisis which marks the end of the current episode. If the individual has another crisis within 7 calendar days of a previous episode, it shall be considered part of the previous episode and a new episode will not be allowed.
☑	Medically needy *(specify limits):*
	LMHP limitations: Providers cannot provide services or supervision under this section if they are a provider who is excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. In addition, they may not be debarred, suspended, or otherwise excluded from participating in procurement activities under the State and Federal laws, regulations, and policies including the Federal Acquisition Regulation, Executive Order No.12549, and Executive Order No. 12549. In addition, providers who are an affiliate, as defined in the Federal Acquisition Regulation, of a person excluded, debarred, suspended or otherwise excluded under State and Federal laws, regulations, and policies may not participate. All services must be authorized. Services which exceed the limitation of the initial authorization must be approved for re-authorization prior to service delivery. In addition to licensure, service providers that offer addiction services must demonstrate competency as defined by the Department of Health and Hospitals, state law (ACT 803 of the Regular Legislative Session 2004) and regulations. Anyone providing addiction or behavioral health services must be certified by DHH, in addition to their scope of practice license. LMFTs and LACs are not permitted to diagnose under their scope of practice under state law. LPCs are limited by scope of practice under state law to diagnosing conditions or disorders requiring mental health counseling and may not use appraisal instruments, devices or procedures for the purpose of treatment planning, diagnosis, classification or description of mental and emotional disorders and disabilities, or of disorders of personality or behavior, which are outside the scope of personal problems, social concerns, educational progress and occupations and careers. Inpatient hospital visits are limited to those ordered by the individual's physician. Visits to nursing facility are allowed for psychologists if a PASRR (Preadmission Screening and Resident Review indicates it is medically necessary treatment. Social worker visits are included in the Nursing Visit and may not be billed separately. Visits to ICF-MR facilities are non-covered. All LMHP services provided while a person is a resident of an IMD such as a free standing psychiatric hospital or psychiatric residential treatment facility are content of the institutional service and not otherwise reimbursable by Medicaid. Evidence-based Practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by DHH. CPST, PR, and CI Limitations: Services are subject to prior approval, must be medically necessary and must be recommended by a licensed mental health practitioner or physician according to an individualized treatment plan. The activities included in the service must be intended to achieve identified treatment plan goals or objectives. The treatment plan should be developed in a person-centered manner with the active participation of the individual, family and providers and be based on the individual's condition and the standards of practice for the provision of these specific rehabilitative services. The treatment plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The treatment plan must specify the frequency, amount and duration of services. The treatment plan must be signed by the licensed mental health practitioner or physician responsible for developing the plan. The plan will specify a timeline for reevaluation of the plan that is at least an annual redetermination. The reevaluation should involve the individual, family and providers and include a reevaluation of plan to determine

whether services have contributed to meeting the stated goals. A new treatment plan should be developed if there is no measureable reduction of disability or restoration of functional level. The new plan should identify different rehabilitation strategy with revised goals and services. Anyone providing addiction or mental health services must be certified by DHH, in addition to any required scope of practice license required for the facility or agency to practice in the State of Louisiana. Providers must maintain case records that include a copy of the treatment plan, the name of the individual, dates of services provided, nature, content and units of rehabilitation services provided, and progress made toward functional improvement and goals in the treatment plan. Medical necessity of the services is determined by a licensed mental health practitioner or physician conducting an assessment consistent with state law, regulation and policy. Services provided at a work site must not be job tasks oriented. Any services or components of services the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, child care, and laundry services) are non-covered. Services cannot be provided in an institute for mental disease (IMD). Room and board is excluded from any rates provided in a residential setting. Evidence-based Practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by DHH. Services may be provided at a site-based facility, in the community or in the individual's place of residence as outlined in the Plan of Care. Components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual are not eligible for Medicaid reimbursement.

CPST Limitations: Caseload Size must be based on the needs of the clients/families with an emphasis on successful outcomes and individual satisfaction and must meet the needs identified in the individual treatment plan. The CPST provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a LMHP or PIHP-designated LMHP with experience regarding this specialized mental health service. All analysis of problem behaviors must be performed under the supervision of a licensed psychologist/medical psychologist.

PSR Limitation: Limit of 750 hours of group psychosocial rehabilitation per calendar year. This limit can be exceeded when medically necessary through prior authorization. The PR provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a LMHP or PIHP-designated LMHP with experience regarding this specialized mental health service.

CI Limitations: All individuals who self-identify as experiencing a seriously acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it are eligible. An individual in crisis may be represented by a family member or other collateral contact who has knowledge of the individual's capabilities and functioning. Individuals in crisis who require this service may be using substances during the crisis**.** Substance use should be recognized and addressed in an integrated fashion as it may add to the risk increasing the need for engagement in care. The assessment of risk, mental status, and medical stability must be completed by a LMHP or PIHP-designated LMHP with experience regarding this specialized mental health service, practicing within the scope of their professional license. The crisis plan developed from this assessment and all services delivered during a crisis must be provided under the supervision of a LMHP or PIHP-designated LMHP with experience regarding this specialized mental health service, and such must be available at all times to provide back up, support, and/or consultation. Crisis services cannot be denied based upon substance use. The Crisis Intervention specialist must receive regularly scheduled clinical supervision from a person meeting the qualifications of a LMHP or PIHP-designated LMHP with experience regarding this specialized mental health service. Crisis Intervention – Emergent is limited to 6 hours per episode. Crisis Intervention – Ongoing is limited to 66 hours per episode. An episode is defined as the initial face to face contact with the individual until the current crisis is resolved, not to exceed 14 days. The individual's chart must reflect resolution of the crisis which marks the end of the current episode. If the individual has another crisis within 7 calendar days of a previous episode, it shall be considered part of the previous episode and a new episode will not be allowed.

Specify whether the service may be provided by a *(check each that applies):*	☐	Relative
	☐	Legal Guardian
	☐	Legally Responsible Person

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency		Mental Health Rehabilitation Certification	Certified agencies may provide any component of the

			Rehabilitation services listed and must employ and utilize the qualified providers as listed below (LMHPs, CPST specialists, PR specialists, and CI specialists)
Clinic	Mental Health Clinic RS 28:567		Clinics may provide any component of the Rehabilitation services listed and must employ and utilize the qualified providers as listed below (LMHPs, CPST specialists, PR specialists, and CI specialists)
LMHP	A LMHP includes individuals 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)		Practitioners must operate under the scope of practice as outlined in state law.
CPST specialists			Must have a MA/MS degree to provide all aspects of CPST including counseling. Other aspects of CPST except for counseling may otherwise be performed by an individual with BA/BS or four years of equivalent education and/or experience working in the human services field. Certification in the State of Louisiana to provide the service, which includes criminal, abuse/neglect registry

			and professional background checks, and completion of a state approved standardized basic training program.
Psychosocial Rehabilitation specialist			Must have meet PRS requirements to provide all aspects of PRS subcomponents of Rehabilitation. Must be at least 18 years old, and have a high school diploma or equivalent. Additionally, the provider must be at least three years older than an individual under the age of 18. Certification in the State of Louisiana to provide the service, which includes criminal, professional background checks, and completion of a state approved standardized basic training program.
Crisis Intervention Specialist			Must have meet CI requirements to provide all aspects of CI subcomponents of Rehabilitation. Must be at least 20 years old and have an AA/AS degree or two years of equivalent education and/or experience working in human services field. Additionally, the provider must be at least three years older than an individual under the age of 18. Certification in the State of Louisiana to provide the service, which includes criminal, professional background checks, and completion of a state approved standardized basic training program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	Managed care entity	Upon contracting and at least annually thereafter, the managed care entity will conduct an on-site audit to ensure that all providers are appropriately credentialed

Clinic	Managed care entity	Upon contracting and at least annually thereafter, the managed care entity will conduct an on-site audit to ensure that all providers are appropriately credentialed

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Psychiatrist services
Service Definition (Scope)*:*	
As approved in the Medicaid State Plan under Attachment 3.1A, item 12.a. Physician (for Psychiatrist Specialty only).	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
☑	Categorically needy *(specify limits):*
	Individuals must access under 1905(a) of the State Plan.
☑	Medically needy *(specify limits):*
	Available to individuals unable to access under 1905(a) of the State Plan.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
As approved in Physician, Psychiatrist specialty, Attachment 3.1-A, Item 5.			

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
As approved in Physician, Psychiatrist, Attachment 3.1-A, Item 5.	Managed care entity	Upon enrollment and every 5 years thereafter.

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	Provider managed

2. ☑ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the State assures that):* There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS ; (b) how the State ensures that the provision of services by such persons is in the best interest of the individual; (c) the State's strategies for ongoing monitoring of services provided by such persons; (d) the controls to ensure that payments are made only for services rendered; and (e) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

The State does not make (and will not permit the managed care entity to make) payment to legally responsible individuals, other relatives, or legal guardians for furnishing state plan Home and Community Based Services (HCBS).

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (*Select one):*

●	The State does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. *(Specify criteria):*

2. Description of Participant-Direction. *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect self-directed service delivery options offered by the State, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the State affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

5. Financial Management. (*Select one):*

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Plan of Care.** *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

6. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). (*Select one):*

●	The State does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget). (*Select one):*

●	The State does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):*

Quality Improvement Strategy

(Describe the State's quality improvement strategy in the tables below):
Discovery Evidence: *Performance Measures*
Discovery Activity: *Source of Data and sample size*
Monitoring Responsibilities: *agency or entity that conducts discovery activities*
Remediation responsibilities: *who corrects, analyzes and aggregates remediation activities; required timeframes for remediation*
Frequency *of analysis and aggregation*

Discovery Activities					Remediation	
Requirement	**Discovery Evidence**	**Discovery Activity**	**Monitoring Responsibilities**	**Frequency**	**Remediation Responsibilities**	**Frequency**
The processes and instruments described in the approved 1915(i) SPA are applied appropriately and according to the approved description to determine participant if the needs-based criteria was met.	LOC1: Number and percent of new enrollees who meet the level of care requirements prior to receipt of services LOC2: Number and percent of participants whose level of care determination forms/instruments were completed timely as required by the state. LOC3: Number and percent of participants whose level of care determination form/instruments were completed correctly. LOC4: Number and percent of level of care determinations made by a qualified evaluator.	LOC1: 100% review. LOC2-4: Onsite record review, less than a 100% sample with a 95% confidence level	Managed care entity collects and aggregates the data; operating agency and the managed care entity analyze the data	Quarterly	Managed care entity	Analysis and aggregation are quarterly. If a corrective action plan is needed it must be provided within 30 business days.
Treatment plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	POC1: Number and percent of participants whose plan of care reflects supports and services necessary to address the participant's goals.	Onsite record review, less than 100% sample with a 95% confidence level.	Managed care entity collects and aggregates the data; operating agency and the managed care entity analyze the data.	Quarterly	Managed care entity	Analysis and aggregation are quarterly. If a corrective action plan is needed it must be provided within 30 business days.

	POC2: Number and percent of participants whose services plans include supports and services consistent with assessed needs, including risks. POC3: Number and percent of participants who participated in the plan of care development, as documented by the participant/authorized representative's signature on the plan of care. POC4: Number and percent of participants whose plan of care was updated timely, as specified in the waiver application. POC5: Number and percent of participants whose plan of care was updated when the participant's needs changed. POC6: Number and percent of participants who received services in the type, amount, duration, and frequency specified in the plan of care. POC7: Number and percent of participants given a choice among service providers, as documented by the participant/ authorized representative's signature on the State-approved form. POC8: Number and percent of participants who received information on available HCBS, as documented by the	POC4: 100% review				

	participant/authorized representative's signature on the State-approved form.					
Providers meet required qualifications.	QP1: Number and percent of providers initially meeting licensing, training, and/or certification requirements prior to furnishing waiver services. QP2: Number and percent of providers continuously meeting licensing and/or certification requirements. QP3: Number and percent of non-licensed direct care staff of providers that meet State requirements. QP4: Number and percent of providers meeting ongoing training requirements.	100% review	Managed care entity collects and aggregates the data, operating agency and the managed care entity analyze the data.	Quarterly	Managed care entity	Analysis and aggregation are quarterly. If a corrective action plan is needed it must be provided within 30 business days.
The SMA retains authority and responsibility for program operations and oversight.	1. Number and/or percent of aggregated performance measure reports generated by the Operating Agency and reviewed by the State Medicaid Agency that contain discovery, remediation, and system improvement for ongoing compliance of the assurances. 2. Number and/or percent of waiver amendments, renewals, and financial reports approved by the State Medicaid Agency (BHSF) prior to	100% review	Medicaid and the operating agency collect and review data.	Quarterly	Medicaid and the operating agency	Analysis and aggregation are quarterly. If a corrective action plan is needed it must be provided within 30 business days.

	implementation by the Operating Agency (OBH). 3. Number and/or percent of waiver concepts and policies requiring MMIS programming approved by the State Medicaid Agency prior to the development of a formal implementation plan by the Operating Agency.					
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	FA1: Number and percent of paid claims that contained the appropriate billing unit, procedure code and modifier. FA2: Number and percent of paid claims that contained appropriate documentation to support payment. FA3: Number and percent of claims that paid in accordance with the approved rate.	FA1 and FA3: 100% review FA2: Onsite record review, less than 100% sample with a 95% confidence level.	Managed care entity collects and aggregates the data; operating agency and the managed care entity analyze the data.	Quarterly	Managed care entity	Analysis and aggregation are quarterly. If a corrective action plan is needed it must be provided within 30 business days.
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	HW1: Number and percent of abuse, neglect, exploitation, death investigations that were completed within the required timeframes. HW2: Number and percent of critical incidents that were investigated within the established timeframe. HW3: Number and percent of participants who received information about how to report critical incidents, as documented by the	HW1,HW2, HW4: 100% review. HW3, HW5: Onsite record, less than 100% review with 95% confidence level	Managed care entity collects and aggregates the data; operating agency and managed care entity analyze the data.	Quarterly	Managed care entity	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days.

	participant/authorized representative's signature on the State-approved form. HW4: Number and percent of providers that have received training in de-escalation techniques without the use of restraints or seclusion. HW5: Number and percent of participants who received coordination and support with accessing health care services identified in their plan of care.					

System Improvement: *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)*			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
The Quality Assurance Performance Improvement committee meets on a quarterly basis to review data reports and to determine if the measure results are satisfactory or indicate a need for corrective action or system level changes.	Review and analyze performance measure reports, member and provider survey reports, grievance data, network adequacy reports, and utilization management reports. Identify areas where improvement is needed, set goals for improvement, and monitor to ensure appropriate actions are taken by the managed care entity in a timely manner to address identified issues. Conduct compliance reviews to ensure the managed care entity meets federal and state requirements.	Reports are reviewed /analyzed by the quality committee at least quarterly. The compliance review is conducted annually and in accordance with CMS's established protocols.	During the quarterly Quality Assurance Performance Improvement meetings, the need for new system changes as well as the effectiveness of previous system changes will be discussed and evaluated.

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☐	HCBS Respite Care
☑	Other
	As described in Attachment 4.19 B, Item 5. Reimbursement for Psychiatrists under Physician.

For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☑	HCBS Psychosocial Rehabilitation

The 1915(i) is being implemented concurrent with a 1915(b) waiver. Concurrent §1915(b)/§1915(i) authorities will utilize a capitated payment arrangement. The capitation will be described in the State's 1915(b) waiver and approved contract consistent with 42 CFR 438.6(c). The description below is the State Plan FFS reimbursement methodology on which capitation payments are based.

A. State Plan Reimbursement Methodology

Reimbursements for services are based upon a Medicaid fee schedule established by the State of Louisiana. The reimbursement rates for physician services rendered under the Louisiana Behavioral Health Partnership (LBHP) shall be a flat fee for each covered service as specified on the established Medicaid fee schedule. The reimbursement rates shall be based on a percentage of the Louisiana Medicare Region 99 allowable for a specified year.

Effective for dates of service on or after April 20, 2013, the reimbursement for behavioral health services rendered by a physician under the LBHP shall be 75 percent of the 2009 Louisiana Medicare Region 99 allowable for services rendered to Medicaid recipients.

Effective for dates of service on or after September 1, 2013, the reimbursement for procedure codes 90791, 90792, 90832, 90834, and 90837 shall be excluded from the January 2013 Medicare rate changes and shall remain at the Medicaid fee schedule on file as of December 31, 2012.

If a Medicare fee exists for a defined covered procedure code, then Louisiana will pay Psychologists and ARNP at 80% of the LBHP physician rates. If a Medicare fee exists for a defined covered procedure code, then Louisiana will pay LCSWs, LPCs, LMFTs, and LAC's as well as qualified unlicensed practitioners delivering substance abuse services at 70% of the LBHP physician rates.

Where Medicare fees do not exist for a covered code, the fee development methodology will build fees considering each component of provider costs as outlined below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the Plan are available to individuals at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.

Except as otherwise noted in the Plan, the State-developed fee schedule is the same for both governmental and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in (specify where published including website location).

The Agency's fee schedule rate was set as of March 1, 2012 and is effective for services provided on or after that date. All rates are published on the agency's website at www.lamedicaid.com.

The fee development methodology will primarily be composed of provider cost modeling, though Louisiana provider compensation studies, cost data and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in fee development.

- Staffing Assumptions and Staff Wages
- Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)
- Program-Related Expenses (e.g., supplies)
- Provider Overhead Expenses
- Program Billable Units

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units. Effective for dates of service on or after January 20, 2013, supplemental Medicaid payments for state-owned and operated behavioral health providers shall be made in accordance with the payment methodology as described under **Attachment 4.19-B, Item 13d, page 8.** B. Standards for Payment 1. Providers must meet provider participation requirements including certification and licensure of agencies and clinic, 2. All services must be prior authorized and provided in accordance with the approved Plan of Care. 3. Providers must comply with all state and federal regulations regarding subcontracts.
HCBS Clinic Services (whether or not furnished in a facility for CMI)