RULE

Department of Health
Bureau of Health Services Financing

Applied Behavior Analysis-Based Therapy Services
Custodial Care Services
(LAC 50:XV.301)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XV.301 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

TITLE 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XV. Services for Special Populations
Subpart 1. Applied Behavior Analysis-Based Therapy Services

Chapter 3. Services

§301. Covered Services and Limitations

A. - F.4. ...

5. custodial care;

a. - a.i. ...

ii. is provided primarily for maintaining the recipient's or anyone else's safety; or

5.a.iii. – 6.d. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:926 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Home and Community-Based Services Providers Licensing Standards
(LAC 48:I.Chapters 50 and 51)

The Department of Health, Bureau of Health Services Financing has amended LAC 48:I.Chapters 50 and 51 as authorized by R.S. 36:254 and R.S. 40:2120.2. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, 49:950 et seq.

Title 48

PUBLIC HEALTH–GENERAL
Part I. General Administration
Subpart 3. Licensing and Certification

Chapter 50. Home and Community-Based Services Providers Licensing Standards

Subchapter A. General Provisions

§5001. Introduction

A. Pursuant to R.S. 40:2120.2, the Department of Health (LDH) has established the minimum licensing standards for home and community-based services (HCBS) providers. These licensing provisions contain the core requirements for HCBS providers as well as the module-specific requirements, depending upon the services rendered by the HCBS provider. These regulations are separate and apart from Medicaid standards of participation or any other requirements established by the Medicaid Program for reimbursement purposes.

B. – C.8. ...

D. The following entities shall be exempt from the licensure requirements for HCBS providers:

1. – 1.a. ...

b. provides sitter services;

c. ...

d. provides home modifications/environmental accessibility adaptations and/or assessments; or

e. provides personal emergency response system/assistive technology/devices;

D.2. – 4. ...

5. any person who is employed as part of a departmentally authorized self-direction program; and

5.a. ...

6. any agency that provides residential orientation and adjustment programs for blind persons.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:63 (January 2012), amended LR 38:1410 (June 2012), LR 40:1007 (May 2014), LR 41:2638 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5003. Definitions

***

Activities of Daily Living (ADLs)—the functions or basic self-care tasks which are performed by an individual in a typical day, either independently or with supervision/assistance. Activities of daily living may include, but are not limited to, bathing, dressing, eating, grooming, walking, transferring and/or toileting.

***

Assistance with Activities of Daily Living-services that provide assistance with activities of daily living. Such assistance may be the actual performance of the tasks for the individual, hands-on assistance with the performance of the tasks, or supervision and prompting to allow the individual to self-perform such tasks.

Branch—an office from which in-home services such as personal care attendant (PCA), supervised independent living (SIL) and respite are provided within the same LDH region served by the parent agency. The branch office shares administration and supervision.

Cessation of Business–provider is non-operational and/or has stopped offering or providing services to the community.

C*hange in Health Status*-a significant decline in the client's health that will not normally resolve itself without further assessment and/or intervention by staff or licensed medical practitioners.

***

Department—the Louisiana Department of Health (LDH) or any of its sections, bureaus, offices or its contracted designee.

LDH Region—the geographic administrative regions designated by the Department of Health.

***

Employed-performance of a job or task for compensation, such as wages or a salary. An employed person may be one who is contracted or one who is hired for a staff position.

***

Geographic Location—the LDH region in which the primary business location of the provider agency operates from.

Health Standards Section (HSS)—the licensing and certification section of the Department of Health.

***

Individual Service Plan—a service plan, person centered and developed for each client, that is based on a comprehensive assessment which identifies the individual's strengths and needs in order to establish goals and objectives so that outcomes to service delivery can be measured.

NOTE: For those clients receiving Medicaid reimbursed home and community-based services, a comprehensive plan of care prepared in accordance with policies and procedures established by Medicaid or by an LDH program office for reimbursement purposes may be substituted or used for the individual service plan.

Individuals with Disabilities Education Act (IDEA)-the law ensuring services to children with disabilities through the U.S. Department of Education which may include vocational training.

Instrumental Activities of Daily Living (IADLs)—the functions or tasks that are not necessary for fundamental functioning but assist an individual to be able to live in a community setting. These are activities such as light house-keeping, food preparation and storage, grocery shopping, laundry, reminders to take medication, scheduling medical appointments, arranging transportation to medical appointments and assistance attending medical appointments if needed.

Line of Credit–A credit arrangement with a federally insured, licensed lending institution which is established to assure that the provider has available funds as needed to continue the operations of the agency and the provision of services to clients. The line of credit shall be issued to the licensed entity and shall be specific to the geographic location shown on the license. For purposes of HCBS licensure, the line of credit shall not be a loan, credit card or a bank balance.

Mental Abuse–includes, but is not limited to abuse that is facilitated or caused by taking or using photographs or recordings in any manner that would demean or humiliate a client using any type of equipment (e.g., cameras, smart phones, and other electronic devices) and/or keeping or distributing them through multimedia messages or on social media sites.

1. Mental abuse may occur through either verbal or nonverbal conduct which causes or has the potential to cause the client to experience humiliation, intimidation, fear, shame,

agitation, or degradation, regardless of whether the client provided consent and regardless of the client's cognitive status. This may include, but is not limited to:

a. photographs and recordings of clients that contain nudity;

b. sexual and intimate relations;

c. bathing, showering or toileting;

d. providing perineal care such as after an incontinence episode;

e agitating a client to solicit a response;

f. derogatory statements directed to the resident;

g. showing a body part without the client's face, whether it is the chest, limbs or back;

h. labeling a client's pictures and/or providing comments in a demeaning manner;

i. directing a client to use inappropriate language; and/or

j. showing a client in a compromised position.

***

Non-Operational-the HCBS provider location is not open for business operation on designated days and hours as stated on the licensing application and business location signage.

***

Respite Care—an intermittent service designed to provide temporary relief to unpaid, informal caregivers of the elderly and/or persons with disabilities.

Satellite—an alternate location from which center-based respite or adult day care services are provided within the same LDH region served by the parent agency. The satellite office shares administration and supervision.

Service Area—the LDH administrative region in which the provider's geographic business location is located and for which the license is issued.

***

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:64 (January 2012), amended LR 40:1007 (May 2014), LR 41:2638 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5005. Licensure Requirements

A. All HCBS providers shall be licensed by the Department of Health. It shall be unlawful to operate as a home and community-based service provider without a license issued by the department. LDH is the only licensing authority for HCBS providers in Louisiana.

B. An HCBS license shall:

1. – 3. ...

4. enable the provider to render delineated home and community-based services within a LDH region;

5. – 8. ...

C. An HCBS provider shall provide only those home and community-based services or modules:

1. ...

2. only to clients residing in the provider's designated service area, LDH Region, or at the provider's licensed location.

D. An HCBS provider may apply for a waiver from the Health Standards Section (HSS) to provide services to a client residing outside of the provider's designated service area or LDH Region only under the following conditions:

1. A waiver may be granted by the department if there is no other HCBS provider in the client's service area or LDH Region that is licensed and that has the capacity to provide the required services to the client, or for other good cause shown by the HCBS provider and client.

2. The provider shall submit a written waiver request to HSS prior to providing services to the client residing outside of the designated service area or LDH Region.

D.3. - E. ...

1. Each HCBS provider shall have a business location which shall not be located in an occupied personal residence and shall be in accordance with the provisions of §5027 and §5031 of this Chapter.

a. The business location shall be part of the licensed location of the HCBS provider and shall be in the LDH Region for which the license is issued.

b. The business location shall have at least one employee, either contracted or staff, on duty at the business location during the days and hours of operation as stated on the licensing application and business location signage.

c. ...

2. The ADC shall be open at least five hours on days of operation. Center-based respite facilities shall have the capacity to provide 24 hour services.

3. There shall be a sufficient number of trained direct care staff and professional services staff, either employed or contracted, available to be assigned to provide services to persons in their homes as per the plan of care. ADC services and center-based respite services should be sufficiently staffed during the facility's hours of operation.

E.4. – G. ...

H. If applicable, each HCBS provider shall obtain facility need review approval prior to initial licensing.

1. If an existing licensed HCBS provider who is not currently providing PCA, respite, MIHC or SIL services wants to begin providing these services, the provider shall be required to apply for facility need review approval for each of the requested services.

H.2. – J.1. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:65 (January 2012), amended LR 41:2638 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5007. Initial Licensure Application Process

A. ...

B. The initial licensing application packet shall include:

1. – 2. ...

3. a copy of the on-site inspection report for the adult day care module and the center-based respite module with approval for occupancy by the Office of the State Fire Marshal;

4. ...

5. a copy of a statewide criminal background check, conducted by the Louisiana State Police, or its authorized agent, including sex offender registry status, on all owners and administrators;

a. each owner shall be at least aged 18 years;

6. proof of financial viability, comprised of the following:

a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $50,000 that is:

i. current at the time of submission of the application for licensure; and

ii. issued to/in the name of the applicant at the geographic location shown on the application for licensure;

b. general and professional liability insurance in the amount of at least $300,000 that is current and in effect at the time of license application; and

c. worker's compensation insurance that is current and in effect at the time of license application;

NOTE: The LDH Health Standards Section shall specifically be identified as the certificate holder on these policies pursuant to §5007.B.6.a-c and any certificates of insurance issued as proof of insurance by the insurer or producer (agent). The policy shall have a cancellation/change statement requiring notification of the certificate holder 30 days prior to any cancellation or change of coverage.

7. a completed disclosure of ownership form which includes any controlling interest or ownership in any other licensed agencies;

8. - 10. ...

C. A person convicted of one or more of the following felonies is prohibited from being the owner or the administrator of an HCBS provider agency. For purposes of these provisions, the licensing application shall be rejected by the department for any felony conviction relating to:

C.1. – D.1. ...

2. If an initial licensing application is closed, an applicant who is still interested in becoming an HCBS provider shall submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process, subject to any facility need review approval.

E. Applicants for HCBS licensure shall be required to either attend a mandatory HCBS provider training class or complete the LDH online provider training when a completed initial licensing application packet has been received by the department.

F. Upon completion of the mandatory HCBS provider training class and written notification of satisfactory class completion from the department or upon submission of attestation of satisfactory completion of the LDH online provider training, an HCBS applicant shall be required to admit one client and contact the HSS field office to schedule an initial licensing survey.

1. Prior to scheduling the initial survey, applicants shall be:

a. – c. ...

2. If the applicant has not admitted one client or contacted the HSS field office to schedule an initial survey within 30 days of receipt of the written notification from the department, the application will be closed. If an applicant is still interested in becoming an HCBS provider, a new initial licensing packet with a new initial licensing fee shall be submitted to the department to start

the initial licensing process, subject to any facility need review approval.

G. Applicants shall be in compliance with all appropriate federal, state, departmental or local statutes, laws, ordinances, rules, regulations and fees before the HCBS provider will be issued an initial license to operate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:66 (January 2012), amended LR 41:2638 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5009. Initial Licensing Surveys

A. – D.2. ...

E. The initial licensing survey of an HCBS provider shall be an announced survey. Follow-up surveys to the initial licensing survey are unannounced surveys.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:66 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5011. Types of Licenses and Expiration Dates

A. – A.3. ...

B. The department, in its sole discretion, may issue a provisional license to an existing licensed HCBS provider for a period not to exceed six months. The department will consider the following circumstances in making a determination to issue a provisional license:

1. compliance history of the provider to include areas of deficiencies cited;

2. the nature and severity of any substantiated complaints;

a. Repealed.

3. – 5. ...

C. When the department issues a provisional license to an existing licensed HCBS provider, the provider shall submit a plan of correction to LDH for approval, and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license. The department shall conduct a follow-up survey, either on-site or by desk review, of the HCBS provider prior to the expiration of the provisional license.

C.1. – D.3. ...

E. The renewal of a license does not in any manner affect any sanction, civil fine or other action imposed by the department against the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:67 January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5012. Change in License by Addition or Deletion of a Service Module or Modules from the HCBS License

A. Addition of a Service Module or Modules to existing HCBS License

1. An HCBS provider with an active HCBS license, current and in good standing, may submit a request to add a service module or modules. The following information shall be submitted for consideration of this request:

a. a completed HCBS license application which has "Add a Service" clearly marked;

b. a facility need review approval letter, if seeking to add the PCA, SIL, MIHC, or respite service modules; and

c. applicable fee for issuance of the new HCBS license.

B. Deletion of a Service Module or Modules to existing HCBS License

1. An HCBS provider with an active HCBS license may submit a request to delete a service module or modules. The following information shall be submitted for consideration of this request:

a. a completed HCBS license application which has "Delete a Service" clearly marked; and

b. applicable fee for issuance of the new HCBS license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:

§5013. Changes in Licensee Information, Location, or Key Personnel

A. – C.2.d. ...

D. If the HCBS provider changes its name without a change in ownership, the HCBS provider shall report such change to the department in writing five days prior to the change. The change in the HCBS provider name requires a change in the HCBS provider license. Payment of the applicable fee is required to re-issue the license.

1. – 2. Repealed.

E. Any request for a duplicate license shall be accompanied by the applicable fee.

F. If the HCBS provider changes the physical address of its geographic location without a change in ownership, the HCBS provider shall report such change to LDH in writing at least five days prior to the change. Because the license of an HCBS provider is valid only for the geographic location of that provider, and is not

transferrable or assignable, the provider shall submit a new licensing application.

1. An on-site survey may be required prior to the issuance of the new license.

2. The change in the HCBS provider's physical address results in a new license renewal anniversary date and an additional full licensing fee shall be paid.

G. – G.2. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:68 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5014. Change of Ownership of an HCBS Provider

A. The license of an HCBS provider is not transferable or assignable and cannot be sold.

B. A change of ownership (CHOW) of the HCBS provider shall not be submitted at time of the annual renewal of the provider's license.

C. Before an initial license can be issued to the new owner, all licensing application requirements shall be:

1. completed by the applicant in accordance with the provisions of §5007; and

2. submitted to the department for approval.

D. The applicant shall submit the following licensing requirements to the department:

1. the completed HCBS license application and non-refundable fee;

2. disclosure of ownership documentation;

3. proof of financial viability to include:

a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $50,000 that is current at the time of the application for licensure and is issued to/in the name of the applicant at the geographic location shown on the application for licensure;

b. general and professional liability insurance of at least $300,000 that is current and in effect at the time of application for licensure; and

c. worker's compensation insurance that is current and in effect at the time of application for licensure.

NOTE: The LDH Health Standards Section shall specifically be identified as the certificate holder on these policies pursuant to §5014.D.3.a-c and any certificates of insurance issued as proof of insurance by the insurer or producer (agent). The policy shall have a cancellation/change statement requiring notification of the certificate holder 30 days prior to any cancellation or change of coverage.

4. If center-based services such as adult day care or center-based respite are also being acquired in the change of ownership, the prospective new owner shall be required to submit

approvals for occupancy from OPH and the State Fire Marshal. Such approvals shall be issued under the name of the center as given by the new owner.

E. An HCBS provider may not undergo a CHOW if any of the following conditions exist:

1. licensure is provisional, under revocation or denial of renewal;

2. is in a settlement agreement with the department;

3. has been excluded from participation from the Medicaid program;

4. has ceased to operate and does not meet operational requirements to hold a license as defined by §5031 Business Location and in accordance with §5026 Cessation of Business.

F. The department may deny approval of the CHOW for any of the reasons a license may be revoked or denied renewal pursuant to these licensing provisions.

G. If the CHOW results in a change of geographic address, an on-site survey may be required prior to issuance of the new license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:

§5015. Renewal of License

A. The HCBS provider shall submit a completed license renewal application packet to the department at least 30 days prior to the

expiration of the current license. The license renewal application packet shall include:

1. – 2. ...

3. a current State Fire Marshal report for the adult day care module and the center-based respite module;

4. – 6. ...

7. proof of financial viability, comprised of the following:

a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $50,000 that is current at the time of the application for license renewal and is issued to/in the name of the applicant at the geographic location shown on the application for license renewal;

b. general and professional liability insurance of at least $300,000 that is current and in effect at the time of application for license renewal and has been maintained and in effect throughout the term of the license; and

c. worker's compensation insurance that is current and in effect at the time of application for license renewal and has been maintained and in effect throughout the term of the license.

NOTE: The LDH Health Standards Section shall specifically be identified as the certificate holder on these policies pursuant to §5015.A.7.a-c and any certificates of insurance issued as proof of insurance by the insurer or producer (agent). The policy shall have a cancellation/change statement requiring

notification of the certificate holder 30 days prior to any cancellation or change of coverage.

B. ...

C. Failure to submit a completed license renewal application packet prior to the expiration of the current license shall result in the voluntary non-renewal of the HCBS license.

NOTE: Upon expiration of the current license, the HCBS provider shall cease providing services in accordance with R.S. 40:2120.6 and shall meet the requirements of §5026 Cessation of Business.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:68 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5016. Deemed Status through Accreditation

A. – A.1. ...

2. all services provided under the HCBS license shall be accredited; and

A.3. – B. ...

C. The following may cause the state agency to perform a full licensing survey on an accredited HCBS provider:

1. any substantiated complaints in the preceding 12-month period;

2. addition of service module or modules;

3. ...

4. issuance of a provisional license in the preceding 12-month period;

5. serious violations of licensing standards or professional standards of practice that were cited in the preceding 12-month period that resulted in or had the potential for negative outcomes to clients served; or

6. allegations of inappropriate client treatment or services to a client resulting in death or serious injury.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:68 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5017. Survey Activities

A. – B. ...

C. The department shall require an acceptable plan of correction from a provider for any survey where deficiencies have been cited, regardless of whether the department takes other action against the facility for the deficiencies cited in the survey. The acceptable plan of correction shall be submitted within the prescribed timeframe to the department for approval.

D. ...

E. The department may issue appropriate sanctions for noncompliance, deficiencies and violations of law, rules and regulations. Sanctions include, but are not limited to:

1. civil fines;

2. directed plans of correction;

3. license revocation; and/or

4. denial of license renewal.

F. LDH surveyors and staff shall be:

1. given access to all areas of the provider agency, and to all relevant administrative and/or clinical files during any survey as necessary or required to conduct the survey and/or investigation; and

2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:69 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5019. Statement of Deficiencies

A. – C.1. ...

2. The informal reconsideration of the deficiencies shall be requested in writing within 10 calendar days of receipt of the statement of deficiencies, unless otherwise provided in these standards.

3. The request for informal reconsideration of the deficiencies shall be made to the department's Health Standards Section and will be considered timely if received by HSS within 10 calendar days of the provider's receipt of the statement deficiencies.

4. ...

NOTE: Informal reconsiderations of the results of a complaint investigation are conducted as desk reviews.

5. ...

6. Except as provided for complaint surveys pursuant to R.S. 40:2009.13 et seq., and as provided in these licensing provisions for initial license denials, revocations and denial of license renewals, the decision of the informal reconsideration team shall be the final administrative decision regarding the deficiencies.

a. Repealed.

7. The request for an informal reconsideration of any deficiencies cited as a result of a survey or investigation does not delay submission of the required plan of correction within the prescribed timeframe.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:69 (January

2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5021. Denial of Initial Licensure, Revocation of License, Denial of License Renewal

A. – B.1. ...

2. The department may deny an initial license for any of the reasons a license may be revoked or denied renewal pursuant to these licensing provisions.

3. If the department denies an initial license, the applicant for an HCBS provider license shall discharge the client(s) receiving services.

C. ...

D. Revocation of License or Denial of License Renewal. An HCBS provider license may be revoked or denied renewal for any of the following reasons, including but not limited to:

1. – 4. ...

5. failure to protect a client from a harmful act of an employee, either contracted or staff, or by another client including, but not limited to:

5.a. – 7.e. ...

8. knowingly making a false statement or providing false, forged or altered information or documentation to LDH employees or to law enforcement agencies;

9. – 15. ...

16. failure to repay an identified overpayment to the department or failure to enter into a payment agreement to repay such overpayment;

17. failure to timely pay outstanding fees, fines, sanctions or other debts owed to the department; or

18. failure to maintain current, and in effect, required insurance policies in accordance with the provisions of this Chapter.

E. In the event an HCBS provider license is revoked, renewal is denied or the license is surrendered in lieu of an adverse action, any owner, board member, director or administrator, and any other person named on the license application of such HCBS provider is prohibited from owning, managing, directing or operating another HCBS agency for a period of two years from the date of the final disposition of the revocation, denial action or surrender.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:69 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5023. Notice and Appeal of Initial License Denial, License Revocation and Denial of License Renewal

A. Notice of an initial license denial, license revocation or denial of license renewal shall be given to the provider in writing.

B. The HCBS provider has a right to an administrative reconsideration of the initial license denial, license revocation or denial of license renewal. There is no right to an administrative reconsideration of a voluntary non-renewal or surrender of a license by the provider.

1. The HCBS provider shall request the administrative reconsideration within 15 calendar days of the receipt of the notice of the initial license denial, license revocation or denial of license renewal. The request for administrative reconsideration shall be in writing and shall be forwarded to the department's Health Standards Section. The request for administrative reconsideration shall be considered timely if received by the Health Standards Section within 15 days from the provider's receipt of the notice.

2. The request for administrative reconsideration shall include any documentation that demonstrates that the determination was made in error.

3. If a timely request for an administrative reconsideration is received by HSS, an administrative reconsideration shall be scheduled and the provider will receive written notification of the date of the administrative reconsideration.

4. The provider shall have the right to appear in person at the administrative reconsideration and may be represented by counsel.

5. Correction of a violation or deficiency which is the basis for the initial license denial, revocation or denial of license renewal shall not be a basis for reconsideration.

6. The administrative reconsideration process is not in lieu of the administrative appeals process.

7. The provider will be notified in writing of the results of the administrative reconsideration.

C. The HCBS provider has a right to an administrative appeal of the initial license denial, license revocation or denial of license renewal. There is no right to an administrative appeal of a voluntary non-renewal or surrender of a license by the provider.

1. The HCBS provider shall request the administrative appeal within 30 days of the receipt of the results of the administrative reconsideration.

a. The HCBS provider may forego its rights to an administrative reconsideration, and if so, shall request the administrative appeal within 30 calendar days of the receipt of the written notice of the initial license denial, revocation or denial of license renewal.

2. ...

3. If a timely request for an administrative appeal is received by the Division of Administrative Law, or its successor, the administrative appeal of the license revocation or denial of license renewal shall be suspensive, and the provider shall be

allowed to continue to operate and provide services until such time as the department issues a final administrative decision.

a. If the secretary of the department determines that the violations of the provider pose an imminent or immediate threat to the health, welfare or safety of a client, the imposition of the license revocation or denial of license renewal may be immediate and may be enforced during the pendency of the administrative appeal. If the secretary of the department makes such a determination, the provider will be notified in writing.

4. Correction of a violation or a deficiency which is the basis for the initial license denial, license revocation or denial of license renewal shall not be a basis for an administrative appeal.

D. ...

E. If a timely administrative appeal has been filed by the provider on an initial license denial, denial of license renewal or license revocation, the Division of Administrative Law, or its successor, shall conduct the hearing in accordance with the Administrative Procedure Act.

1. If the final agency decision is to reverse the initial license denial, denial of license renewal or license revocation, the provider's license will be re-instated or granted upon the payment of any licensing fees, outstanding sanctions or other fees due to the department.

2. If the final agency decision is to affirm the denial of license renewal or license revocation, the provider shall discharge any and all clients receiving services according to the provisions of this Chapter.

a. Within 10 calendar days of the final agency decision, the provider shall notify HSS, in writing, of the secure and confidential location where the client records will be stored and the name and contact information of the person(s) responsible for the client records.

F. There is no right to an administrative reconsideration or an administrative appeal of the issuance of a provisional initial license to a new HCBS provider, or the issuance of a provisional license to an existing HCBS provider. A provider who has been issued a provisional license is licensed and operational for the term of the provisional license. The issuance of a provisional license is not considered to be a denial of initial licensure, denial of license renewal or license revocation.

G. A provider with a provisional initial license or an existing provider with a provisional license that expires due to noncompliance or deficiencies cited at the follow-up survey, shall have the right to an informal reconsideration and the right to an administrative appeal, solely as to the validity of the deficiencies.

1. – 2. ...

3. The provider shall request the informal reconsideration in writing, which shall be received by the Health Standards Section within five calendar days of receipt of the written notice of the results of the follow-up survey from the department.

4. The provider shall request the administrative appeal within 15 calendar days of receipt of the written notice of the results of the follow-up survey from the department. The request for administrative appeal shall be in writing and shall be submitted to the Division of Administrative Law, or its successor.

5. – 5.a. ...

6. If a timely administrative appeal has been filed by a provider with a provisional initial license that has expired, or by an existing provider whose provisional license has expired under the provisions of this Chapter, the Division of Administrative Law, or its successor, shall conduct the hearing in accordance with the Administrative Procedure Act.

a. ...

b. If the final agency decision is to uphold the deficiencies thereby affirming the expiration of the provisional license, the provider shall ensure an orderly discharge and transition of any and all clients receiving services in accordance with the provisions of this Chapter.

i. Within 10 calendar days of the final agency decision, the provider shall notify HSS in writing of the secure and confidential location where the client records will be stored.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:70 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5024. Inactivation of License due to a Declared Disaster or Emergency

A. An HCBS provider licensed in a parish which is the subject of an executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766, may seek to inactivate its license for a period not to exceed one year, provided that the following conditions are met:

1. the licensed provider shall submit written notification to the Health Standards Section within 60 days of the date of the executive order or proclamation of emergency or disaster that:

a. the HCBS provider has experienced an interruption in the provisions of services as a result of events that are the subject of such executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766;

b. the licensed HCBS provider intends to resume operation as an HCBS provider in the same service area;

c. includes an attestation that the emergency or disaster is the sole casual factor in the interruption of the provision of services;

d. includes an attestation that all clients have been properly discharged or transferred to another provider; and

e. provides a list of each client and where that client is discharged or transferred to;

2. the licensed HCBS provider resumes operating as a HCBS provider in the same service area within one year of the issuance of an executive order or proclamation of emergency or disaster in accordance with R.S. 29:724 or R.S. 29:766;

3. the licensed HCBS provider continues to pay all fees and cost due and owed to the department including, but not limited to, annual licensing fees and outstanding civil monetary penalties; and

4. the licensed HCBS provider continues to submit required documentation and information to the department.

B. Upon receiving a completed written request to inactivate a HCBS provider license, the department shall issue a notice of inactivation of license to the HCBS provider.

C. Upon completion of repairs, renovations, rebuilding or replacement, an HCBS provider which has received a notice of

inactivation of its license from the department shall be allowed to reinstate its license upon the following conditions being met.

1. The HCBS provider shall submit a written license reinstatement request to the licensing agency of the department 60 days prior to the anticipated date of reopening.

a. The license reinstatement request shall inform the department of the anticipated date of opening, and shall request scheduling of a licensing survey.

b. The license reinstatement request shall include a completed licensing application with appropriate licensing fees.

2. The provider resumes operating as an HCBS provider in the same service area within one year.

D. Upon receiving a completed written request to reinstate an HCBS provider license, the department shall conduct a licensing survey. If the HCBS provider meets the requirements for licensure and the requirements under this Section, the department shall issue a notice of reinstatement of the HCBS provider license.

1. The licensed capacity of the reinstated license shall not exceed the licensed capacity of the adult day care and center-based respite provider at the time of the request to inactivate the license.

E. No change of ownership in the HCBS provider shall occur until such HCBS provider has completed repairs, renovations, rebuilding or replacement construction, and has resumed operations as an HCBS provider.

F. The provisions of this Section shall not apply to an HCBS provider which has voluntarily surrendered its license and ceased operation.

G. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the HCBS provider license and any applicable facility need review approval for licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:

§5025. Inactivation of License due to a Non-Declared Disaster or Emergency

A. A licensed HCBS in an area or areas which have been affected by a non-declared emergency or disaster may seek to inactivate its license, provided that the following conditions are met:

1. the licensed HCBS shall submit written notification to the Health Standards Section within 30 days of the date of the non-declared emergency or disaster stating that:

a. the HCBS has experienced an interruption in the provisions of services as a result of events that are due to a non-declared emergency or disaster;

b. the licensed HCBS intends to resume operation as an HCBS provider in the same service area;

c. the licensed HCBS attests that the emergency or disaster is the sole causal factor in the interruption of the provision of services; and

d. the licensed HCBS's initial request to inactivate does not exceed one year for the completion of repairs, renovations, rebuilding or replacement of the facility.

NOTE: Pursuant to these provisions, an extension of the 30 day deadline for initiation of request may be granted at the discretion of the department.

e. Repealed.

2. the licensed HCBS continues to pay all fees and costs due and owed to the department including, but not limited to, annual licensing fees and outstanding civil monetary penalties and/or civil fines; and

3. the licensed HCBS continues to submit required documentation and information to the department, including but not limited to cost reports.

4. Repealed.

B. Upon receiving a completed written request to temporarily inactivate a HCBS license, the department shall issue a notice of inactivation of license to the HCBS.

C. Upon the facility's receipt of the department's approval of request to inactivate the facility's license, the facility shall have 90 days to submit plans for the repairs, renovations,

rebuilding or replacement of the facility, if applicable, to the OSFM and the OPH as required.

C.1. – C.2. Repealed.

D. The licensed HCBS shall resume operating as an HCBS in the same service area within one year of the approval of renovation/construction plans by the OSFM and the OPH as required.

EXCEPTION: If the facility requires an extension of this timeframe due to circumstances beyond the facility's control, the department will consider an extended time period to complete construction or repairs. Such written request for extension shall show facility's active efforts to complete construction or repairs and the reasons for request for extension of facility's inactive license. Any approval for extension is at the sole discretion of the department.

1. Repealed.

E. Upon completion of repairs, renovations, rebuilding or replacement of the facility, an HCBS which has received a notice of inactivation of its license from the department shall be allowed to reinstate its license upon the following conditions being met:

1. the HCBS shall submit a written license reinstatement request to the licensing agency of the department;

2. the license reinstatement request shall inform the department of the anticipated date of opening and shall request

scheduling of a licensing or physical environment survey, where applicable; and

3. the license reinstatement request shall include a completed licensing application with appropriate licensing fees.

F. Upon receiving a completed written request to reinstate an HCBS license, the department may conduct a licensing or physical environment survey. The department may issue a notice of reinstatement if the facility has met the requirements for licensure including the requirements of this Subsection.

G. No change of ownership in the HCBS shall occur until such HCBS has completed repairs, renovations, rebuilding or replacement construction and has resumed operations as an HCBS.

H. The provisions of this Subsection shall not apply to an HCBS which has voluntarily surrendered its license and ceased operation.

I. Failure to comply with any of the provisions of this Subsection shall be deemed a voluntary surrender of the HCBS license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:72 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5026. Cessation of Business

A. Except as provided in §5024 and §5025 of these licensing regulations, a license shall be immediately null and void if an HCBS provider becomes non-operational.

B. A cessation of business is deemed to be effective the date on which the HCBS provider ceased offering or providing services to the community and/or is considered non-operational in accordance with §5005.E.1.b.

C. Upon the cessation of business, the HCBS provider shall immediately return the original license to the department.

D. Cessation of business is deemed to be a voluntary action on the part of the provider. The HCBS provider does not have a right to appeal a cessation of business.

E. Prior to the effective date of the closure or cessation of business, the HCBS provider shall:

1. give 30 days' advance written notice to:

a. each client or client's legal representative, if applicable;

b. each client's physician;

c. HSS;

d. OCDD;

e. OAAS;

f. support coordination agency for waiver participants;

g. state contractor for state plan LT-PCS services.

2. provide for a safe and orderly discharge and transition of all of the HCBS provider’s clients.

F. In addition to the advance notice, the provider shall submit a written plan for the disposition of client services related records for approval by the department. The plan shall include the following:

1. The effective date of the closure.

2. Provisions that comply with federal and state laws on storage, maintenance, access, and confidentiality of the closed provider’s client services related records;

3. The name and contact information for the appointed custodian(s) who shall provide the following:

a. access to records and copies of records to the patient or authorized representative, upon presentation of proper authorization(s); and

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction.

4. Public notice regarding access to records, in the newspaper with the largest circulation in close proximity to the closing provider, at least 15 days prior to the effective date of closure.

G. If an HCBS provider fails to follow these procedures, the owners, managers, officers, directors, and administrators may be

prohibited from opening, managing, directing, operating, or owning an HCBS for a period of two years.

H. Once any HCBS provider has ceased doing business, the provider shall not provide services until the provider has obtained a new initial HCBS license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:

Subchapter B. Administration and Organization

§5027. Governing Body

A. – A.3. ...

B. The governing body of an HCBS provider shall:

1. – 8. ...

9. ensure statewide criminal background checks on all unlicensed persons providing direct care and services to clients in accordance with R.S. 40:1203.2 or other applicable state law upon hire;

NOTE: Upon request of the employer with approval of the governing body, each applicant for employment may be fingerprinted in accordance with applicable state law to be used to obtain the criminal history record.

10. ensure that the provider does not hire unlicensed persons who have a conviction that bars employment in accordance with R.S. 40:1203.3 or other applicable state law;

a. the provider shall have documentation on the final disposition of all charges that bars employment pursuant to applicable state law; and

11. ensure that direct support staff comply with R.S. 40:1203.2 or other applicable state law.

NOTE: It is not acceptable for a provider to have a client, family member or legal representative sign a statement that they acknowledge the direct support worker has a conviction that bars employment but they still choose to have that individual as the worker. The provider is expected to be in compliance with statutory requirements at all times.

C. An HCBS provider shall maintain an administrative file that includes:

1. a list of members and officers of the governing body, along with their addresses and terms of membership;

2. minutes of formal meetings and by-laws of the governing body, if applicable;

3. a copy of the current license issued by HSS;

4. an organizational chart of the provider which clearly delineates the line of authority;

5. all leases, contracts and purchases-of-service agreements to which the provider is a party;

6. insurance policies;

7. annual budgets and audit reports; and

8. a master list of all the community resources used by the provider.

9. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:72 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5029. Policy and Procedures

A. The HCBS provider shall develop, implement and comply with provider-specific written policies and procedures related to compliance with this Chapter, including, but not limited to policies and procedures that:

1. – 2. ...

3. provide for the protection of clients' rights; and

4. promote the highest practicable social, physical and mental well-being of clients;

B. The HCBS provider shall have written policies and procedures approved by the owner or governing body, which shall be implemented and followed, that address at a minimum the following:

1. confidentiality and confidentiality agreements;

2. security of files;

3. publicity and marketing, including the prohibition of illegal or coercive inducement, solicitation and kickbacks;

4. personnel;

5. client rights;

6. grievance procedures;

7. client funds;

8. emergency preparedness;

9. abuse, neglect, exploitation and extortion;

10. incidents and accidents, including medical emergencies;

11. universal precautions;

12. documentation;

13. admission and discharge procedures; and

14. safety of the client while being transported by an agency employee, either contracted or directly employed, to include a process for evaluation of the employee's driver's license status inquiry report which may prohibit an employee from transporting clients.

C. The HCBS provider shall develop, implement and comply with written personnel policies that include the following:

1. a plan for recruitment, screening, orientation, ongoing training, development, supervision and performance evaluation of staff members, that includes but is not limited to:

a. standards of conduct;

b. standards of attire to include having identification as an employee of the provider accessible when providing services to clients; and

c. standards of safety to include requirements for ensuring safe transportation of clients by employees, contracted or staff, who provide transportation;

2. written job descriptions for each staff position, including volunteers;

3. policies that shall, at a minimum, be consistent with Office of Public Health guidelines for services provided.

4. an employee grievance procedure;

5. abuse reporting procedures that require all employees, either contracted or directly employed, to report any and all incidents of abuse or mistreatment or misappropriation of client funds, whether that abuse or mistreatment or misappropriation is done by another staff member, a family member, a client or any other person;

6. a written policy to prevent discrimination;

7. a written policy to assure that there is a final disposition of all charges that appear on the staff person's or contracted employee's criminal background check; and

8. a written policy to address prohibited use of social media. The policy shall ensure that all staff, either contracted or directly employed, receive training relative to the restricted use of social media an include, at a minimum ensuring confidentiality of client information and preservation of client dignity and respect, and protection of client privacy and personal and property rights.

D. The HCBS provider shall have written policies and procedures for client behavior management which:

1. prohibit:

a. corporeal punishment;

b. restraints of any kind;

c. psychological and verbal abuse;

d. seclusion;

e. forced exercise;

f. any cruelty to, or punishment of, a client; and

g. any act by a provider which denies:

i. food;

ii. drink;

iii. visits with family, friends or significant others; or

iv. use of restroom facilities;

NOTE: §5029.D.1.g.i-iv is not inclusive of medically prescribed procedures.

2. ensure that non-intrusive positive approaches to address the meaning/origins of behaviors are used prior to the development of a restrictive plan; and

3. cover any behavioral emergency and provide documentation of the event in an incident report format.

E. An HCBS provider shall comply with all federal state and local laws, rules and regulations in the development and implementation of its policies and procedures.

E.1. - E.13. Repealed.

F. An HCBS provider shall ensure that all home and community-based waiver services are delivered in settings that are physically accessible to the client when the setting is controlled by the HCBS provider.

F.1. – I. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORY NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:73 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5031. Business Location

A. All HCBS providers shall have a business location in the LDH Region for which the license is issued. The business location shall be a part of the physical geographic licensed location and shall be where the provider:

1. ...

2. maintains and stores the provider’s personnel records;

3. maintains and stores the provider’s client service records;

4. holds itself out to the public as being a location for receipt of client referrals; and

5. after initial licensure, consistently provides services to at least two clients.

EXCEPTION: Adult Day Care shall have 10 or more clients pursuant to R.S. 40:2120.2(4)(e).

B. The business location shall have:

1. a separate entrance and exit from any other entity, business or trade;

2. signage that is easily viewable indicating the provider's legal or trade name, address and days and hours of business operation as stated in the provider's license application.

a. Any planned deviation of the provider's days and hours of operation shall be reported to the Health Standards Section within five business days.

b. Any unplanned deviation of provider's days and hours of operation shall be reported to the Health Standards Section within two business days.

C. The HCBS provider shall operate independently from any other business or entity, and shall not operate office space with any other business or entity.

1. The HCBS provider may share common areas with another business or entity. Common areas include foyers, kitchens, conference rooms, hallways, stairs, elevators or escalators when used to provide access to the provider's separate entrance.

a. Repealed.

2. Records or other confidential information shall not be stored in areas deemed to be common areas.

C.3. – C.7. Repealed.

D. The business location shall:

1. be commercial office space or, if located in a residential area, be zoned for appropriate commercial use and shall be used solely for the operation of the business;

a. the business location shall not be located in an occupied personal residence;

2. have approval for occupancy from the Office of the State Fire Marshal and the Office of Public Health if located at the same address as an adult day care center or center-based respite;

3. have a published telephone number which is available and accessible 24 hours a day, seven days a week, including holidays;

4. have a business fax number that is operational 24 hours a day, seven days a week;

a. – f. Repealed.

5. have internet access and a working e-mail address;

a. the e-mail address shall be provided to the department as well as any changes to the e-mail address within five working days to assure that the department has current contact information;

b. the e-mail address shall be monitored by the provider on an ongoing basis to receive communication from the department.

6. have space for storage of client records either electronically or in paper form or both in an area that is secure, safe from hazards and does not breach confidentiality of protected health information.

7. – 12. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORY NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:74 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5032. Branch Offices and Satellites of HCBS Providers

A. HCBS providers with branch offices or satellite locations shall meet the following:

1. No branch office or satellite location may be opened without prior written approval from HSS. In order for a branch office or satellite location to be approved, the parent agency shall have maintained a full licensure for the previous twelve month period.

a. The number of any new branch or satellite locations for any provider within a geographic location may be limited at the discretion of HSS.

2. The department may consider the following in making a determination whether to approve a branch office or a satellite location:

a. compliance history of the provider to include the areas of non-compliance of the deficiencies cited within the last 12 months;

b. the nature and severity of any substantiated complaints within the last 12 months;

c. if the parent agency currently has a provisional license;

d. if the parent agency currently is in a settlement agreement with the department;

e. if the parent agency has previously been excluded from participation from the Medicaid program;

f. if the parent agency is currently under license revocation or denial of license renewal;

g. if the parent agency is currently undergoing a change of ownership; and

h. if any adverse action has been taken against the license of other agencies operated by the owner of the parent agency within the previous two year period.

3. The branch office or satellite location shall be held out to the public as a branch, division, or satellite of the parent agency so that the public will be aware of the identity of the agency operating the branch or satellite.

a. Reference to the name of the parent agency shall be contained in any written documents, signs or other promotional materials relating to the branch or satellite.

4. Original personnel files shall not be maintained or stored at the branch office or satellite location.

5. A branch office or a satellite location is subject to survey, including complaint surveys, by the department at any time to determine compliance with minimum licensing standards.

6. A branch office or a satellite location shall:

a. serve as part of the geographic service area approved for the parent agency;

b. retain an original or a duplicate copy of all clinical records for its clients for a 12 month period at the branch or satellite location.

NOTE: If satellite or branch records are not maintained at the parent agency, such shall be made available as requested by the state surveyor without delaying the survey process;

c. maintain a copy of the agency's policies and procedures manual on-site for staff usage;

d. post and maintain regular office hours in accordance with §5031.B; and

e. staff the branch office or satellite location during regular office hours.

7. Each branch office or satellite location shall:

a. fall under the license of the parent agency and be located in the same LDH Region as the parent agency;

b. be assessed the required fee, assessed at the time the license application is made and once a year thereafter for renewal of the branch or satellite license;

NOTE: This fee is non-refundable and is in addition to any other fees that may be assessed in accordance with applicable laws, rules, regulations and standards.

8. Existing branch office or satellite location approvals will be renewed at the time of the parent agency's license renewal, if the parent agency meets the requirements for licensure.

B. Branch Offices of HCBS Providers

1. An HCBS provider who currently provides in-home services such as PCA, respite, MIHC or SIL services may apply to the department for approval to operate a branch office to provide those same services.

a. HCBS providers are limited in the same LDH Region as the parent agency at the discretion of HSS.

C. Satellite Locations of HCBS Providers

1. An HCBS provider who currently provides ADC services or provides center-based respite services may apply to the department for approval to operate a satellite location to provide additional ADC services or center-based respite services at that satellite location.

a. HCBS providers are limited in the same LDH Region as the parent agency at the discretion of the HSS.

NOTE: The HSS may with good cause consider exceptions to the limit on numbers of satellite and/or branch locations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:

Subchapter C. Admission, Transfer and Discharge Criteria

§5033. Admissions

A. An HCBS provider shall have written admissions policies and criteria which shall include the following:

1. – 3. ...

4. legal status of the clients served;

5. - 7. ...

B. The written description of admissions policies and criteria shall be made available to the client and his/her legal representative.

C. An HCBS provider shall ensure that the client, the legal representative or other persons, where appropriate, are provided an opportunity to participate in the admission process.

1. Consents as necessary for care and services shall be obtained from the client or legal representative, if applicable, prior to admission.

2. Where such involvement of the client, the legal representative, where appropriate, or other persons as selected by the client is not possible or not desirable, the reasons for their exclusion shall be recorded.

D. When refusing admission, a provider shall provide a written statement as to the reason for the refusal. This shall be provided to designated representatives of the department or to a client upon request.

E. – F. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:75 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5035. Voluntary Transfers and Discharges

A. A client has the right to choose a provider. This right includes the right to be discharged from his current provider, be transferred to another provider and to discontinue all services.

B. Upon notice by the client or authorized representative that the client has selected another provider or has decided to discontinue services or moves from the geographic region serviced by the provider, the HCBS provider shall have the responsibility of planning for a client's voluntary transfer or discharge.

C. The transfer or discharge responsibilities of the HCBS provider shall include:

1. holding a transfer or discharge planning conference with the client, family, support coordinator, legal representative and advocate, if such are applicable, in order to facilitate an orderly transfer or discharge, unless the client or authorized representative declines such a meeting;

C.2. – D.1. ...

E. The provider shall not coerce the client to stay with the provider agency or interfere in any way with the client's decision to transfer. Failure to cooperate with the client's decision to transfer to another provider may result in further investigation and action as deemed necessary by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:75 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5037. Involuntary Transfers and Discharges

A. ...

1. The client's health has improved sufficiently so that the client no longer requires the services rendered by the provider.

2. ...

3. The client has failed to pay any past due amounts for services received from the provider for which he/she is liable within 15 days after receipt of written notice from the provider.

4. ...

5. The client or family refuses to cooperate or interferes with attaining the care objectives of the HCBS provider.

A.6. – C. ...

1. The written notice shall be sent to the client or to the authorized representative via certified mail, return receipt requested.

2. ...

3. When the client has failed to pay any outstanding amounts for services for which he/she has received from the provider and is liable, written notice may be given immediately. Payment is due within 15 days of receipt of written notice from the provider that an amount is due and owing.

4. – 5. ...

D. The written notice of involuntary transfer or discharge shall include:

1. – 4. ...

5. names of provider personnel available to assist the client or authorized representative and family in decision making and transfer arrangements;

D.6. – F.2.b. ...

3. If a client is given 15 days written notice and files a timely appeal of an involuntary transfer/discharge based on the client's failure to pay any outstanding amounts for services within the allotted time, the provider may discharge or transfer the client.

G. The transfer or discharge responsibilities of the HCBS provider shall include:

1. conducting a transfer or discharge planning conference with the client, family, support coordinator, legal representative and advocate, if such are known, in order to facilitate an orderly transfer or discharge;

G.2. – H. ...

1. The provider shall not be required to provide services if the discharge is due to the client moving out of the provider's geographic region. An HCBS provider is prohibited from providing services outside of its geographic region without the department's approval.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:75 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

Subchapter D. Service Delivery

§5039. General Provisions

A. ...

B. Assessment of Needs

1. Prior to any service being rendered, an HCBS provider shall conduct a thorough assessment of the client's needs to identify where supports and services are needed and whether the provider has the capacity to provide such needed care and services.

2. The provider shall not admit a client for whom they do not have the capacity to safely provide required services.

3. The assessment shall identify potential risks to the client and shall address, at a minimum the following areas:

a. life safety, including, but not limited to:

i. the ability of the client to access emergency services;

ii. the ability of the client to access transportation in order to obtain necessary goods and services (i.e. medical appointments, medications and groceries); and

iii. the ability of the client to evacuate the home in an emergent event, such as a fire in the home, or in the event of a declared disaster.

b. living environment including, but not limited to:

i. presence of physical hazards (i.e. objects that could cause falls, hot water temperatures that could contribute to scalds);

ii. presence of functional utilities; and

iii. presence of environmental hazards (i.e. chemicals, foods not kept at acceptable temperatures);

c. health conditions including, but not limited to:

i. diagnoses;

ii. medications, including methods of administration; and

iii. current services and treatment regimen;

d. functional capacity including but not limited to:

i. activities of daily living;

ii. instrumental activities of daily living including money management, if applicable;

iii. communication skills;

iv. social skills; and

v. psychosocial skills including behavioral needs; and

e. client financial health including, but not limited to:

i. the client's independent ability to manage their own finances;

ii. the client's dependence on a family member or other legal representative to manage the client's finances; and

iii. the client's need for the provider's assistance to manage the client's finances to assure that bills such as rent and utilities are paid timely.

4. The assessment shall be conducted prior to admission and at least annually thereafter. The assessment shall be conducted more often as the client's needs change.

5. An HCBS comprehensive assessment performed for a client in accordance with policies, procedures, and timeframes established by Medicaid or by a LDH program office for reimbursement purposes can substitute for the assessment required under these provisions.

6. The provider shall be familiar with the health condition of clients served. If the client has an observable significant change in physical or mental status, the provider shall ensure that the change is immediately reported so that the client receives needed medical attention by a licensed medical practitioner in a timely manner.

C. – C.4. Repealed.

D. – D.2.d. ...

3. An HCBS plan of care or agreement to provide services signed by the provider or client in accordance with policies, procedures, and timelines established by Medicaid or by a LDH program office for reimbursement purposes can substitute for the agreement required under these provisions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:77 (January

2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5041. Individual Service Plan

A. Upon admission and prior to the initiation of care and services, an individual service plan shall be person centered and developed for each client, based upon a comprehensive assessment.

B. – E. ...

F. The ISP shall include the following components:

1. - 3. ...

4. target dates for completion or re-evaluation of the stated goals;

5. identification of all persons responsible for implementing or coordinating implementation of the plan; and

6. documentation of all setting options for services, including non-disability specific settings, which the provider offered to the client, including residential settings.

G. ...

H. A comprehensive plan of care prepared in accordance with policies, procedures, and timelines established by Medicaid or by a LDH program office for reimbursement purposes may be substituted or used for the individual service plan.

I. Each client's ISP shall be reviewed, revised, updated and amended no less than annually, and more often as necessary, or as designated by the department, to reflect changes in the client's needs, services and personal outcomes.

J. Coordination of Services

1. Client care goals and interventions shall be coordinated in conjunction with other providers rendering care and services and/or caregivers to ensure continuity of care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:77 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5043. Contract Services

A. ...

B. When services are provided through contract, a written contract shall be established. The contract shall include all of the following items:

1. – 4. ...

5. a statement that the contracted personnel shall meet the same qualifications and training requirements as an employee of an HCBS agency who holds the same position;

B.5.a. – D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:77 (January

2012), amended LR 41:2638 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5045. Transportation

A. ...

B. Any vehicle owned by the agency or its employees, either contracted or staff, used to transport clients shall be:

1. ...

2. maintained in an operational condition;

3. operated at an internal temperature that does not compromise the health, safety or needs of the client.

C. The provider shall have proof of liability insurance coverage in accordance with state law for any vehicle owned by the agency or its employees, either contracted or staff, that are used to transport clients. The personal liability insurance of a provider's employee, either contracted or staff, shall not be substituted for the required vehicular insurance coverage.

D. Any staff member of the provider or other person acting on behalf of the provider, who is operating a vehicle owned by the agency or its employees, either contracted or staff, for the purpose of transporting clients shall be properly licensed to operate that class of vehicle in accordance with state law.

E. The provider shall have documentation of successful completion of a safe driving course for each staff or contract employee who transports clients. If the staff or contract employee

does not transport clients, such shall be clearly documented in their personnel record.

1. Employees, either contracted or staff, who are required to transport clients as part of their assigned duties shall successfully complete a safe driving course within 90 days of hiring, every three years thereafter, and within 90 days of the provider's discovery of any moving violation.

F. Upon hire, and annually thereafter, the provider shall at a minimum, obtain a driver's license status inquiry report available on-line from the State Office of Motor Vehicles, for each employee, either contracted or directly employed, who is required to transport clients as part of their assigned duties.

G. The provider shall not allow the number of persons in any vehicle used to transport clients to exceed the number of available seats with seatbelts in the transporting vehicle.

H. – I.3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:78 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

Subchapter E. Client Protections

§5049. Client Rights

A. Unless adjudicated by a court of competent jurisdiction, clients served by HCBS providers shall have the same rights, benefits and privileges guaranteed by the constitution and the laws of the United States and Louisiana, including but not limited to the following:

1. human dignity;

2. impartial access to treatment regardless of:

a. race;

b. religion;

c. sex;

d. ethnicity;

e. age; or

f. disability;

3. cultural access as evidenced by:

a. interpretive services;

b. translated materials;

c. the use of native language when possible; and

d. staff trained in cultural awareness;

4. have sign language interpretation, allow for the use of service animals and/or mechanical aids and devices that assist those persons in achieving maximum service benefits when the person has special needs;

5. privacy;

6. confidentiality;

7. access his/her records upon the client's written consent for release of information;

8. a complete explanation of the nature of services and procedures to be received, including:

a. risks;

b. benefits; and

c. available alternative services;

9. actively participate in services, including:

a. assessment/reassessment;

b. service plan development; and

c. discharge;

10. refuse specific services or participate in any activity that is against their will and for which they have not given consent;

11. obtain copies of the provider's complaint or grievance procedures;

12. file a complaint or grievance without retribution, retaliation or discharge;

13. be informed of the financial aspect of services;

14. be informed of the need for parental or guardian consent for treatment of services, if appropriate;

15. personally manage financial affairs, unless legally determined otherwise;

16. give informed written consent prior to being involved in research projects;

17. refuse to participate in any research project without compromising access to services;

18. be free from mental, emotional and physical abuse, coercion and neglect;

19. be free from all restraints;

20. receive services that are delivered in a professional manner and are respectful of the client's wishes concerning their home environment;

21. receive services in the least intrusive manner appropriate to their needs;

22. contact any advocacy resources as needed, especially during grievance procedures;

23. discontinue services with one provider and freely choose the services of another provider;

24. freedom and support to control their own schedules and activities;

25. access to food at any time; and

26. have visitors of their choosing at any time.

B. An HCBS provider shall assist in obtaining an independent advocate:

1. if the client's rights or desires may be in jeopardy;

2. if the client is in conflict with the provider; or

3. upon any request of the client.

C. The client has the right to select an independent advocate, which may be:

1. a legal assistance corporation;

2. a state advocacy and protection agency;

3. a trusted church or family member; or

a. – d. Repealed.

4. any other competent key person not affiliated in any way with the licensed provider.

5. – 23. Repealed.

D. The client, client's family and legal guardian, if one is known, shall be informed of their rights, both verbally and in writing in a language they are able to understand.

D.1. – F. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:78 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5051. Grievances

A. – C. ...

1. The agency shall provide the grievance procedure in writing to the client at admission and grievance forms shall be made readily available as needed thereafter.

D. ...

E. The administrator of the agency, or his/her designee, shall issue a written report and/or decision within five business days of receipt of the grievance to the:

1. – 3. ...

4. the person initiating the grievance.

F. The agency shall maintain documentation pursuant to §5051.A-E.4.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:79 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

Subchapter F. Provider Responsibilities

§5053. General Provisions

A. ...

B. Additional staff shall be employed or contracted as necessary to ensure proper care of clients and adequate provision of services.

C. ...

D. All client calls to the provider’s published telephone number shall be returned within one business day. Each client shall be informed of the provider’s published telephone number, in writing, as well as through any other method of communication most

readily understood by the client according to the following schedule:

1. – 3. ...

E. HCBS providers shall establish policies and procedures relative to the reporting of abuse, neglect, extortion, or exploitation of clients pursuant to the provisions of R.S. 15:1504-1505, R.S. 40:2009.20 and any subsequently enacted laws. Providers shall ensure that staff complies with these regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:79 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5055. Core Staffing Requirements

A. – B.1.a. ...

b. have a minimum of six years of verifiable experience working in a health or social service related business, plus a minimum of four additional years of verifiable experience working in a field providing services to the elderly and/or persons with developmental disabilities; or

c. is a registered nurse licensed and in good standing with the Louisiana State Board of Nursing and have at least two years' experience in providing care to the elderly or to adults with disabilities.

2. Any person convicted of a felony as defined in these provisions is prohibited from serving as the administrator of an HCBS provider agency.

C. Administrator Responsibilities. The administrator shall:

1. – 4. ...

5. employ, either by contract or staff, qualified individuals and ensure adequate staff education and evaluations;

C.6. – D.1.g. ...

2. Professional staff employed or contracted by the provider shall hold a current, valid professional license issued by the appropriate licensing board.

3. The provider shall maintain proof of annual verification of current professional licensure of all licensed professional staff.

4. All professional services furnished or provided shall be furnished or provided in accordance with professional standards of practice, according to the scope of practice requirements for each licensed discipline.

E. Direct Care Staff

1. The provider shall have sufficient numbers of trained direct care staff to safeguard the health, safety and welfare of clients.

2. – 3. ...

F. Direct Care Staff Qualifications

1. HCBS providers shall ensure that all non-licensed direct care staff, either contracted or employed, meet the minimum mandatory qualifications and requirements for direct service workers as required by R.S. 40:2179-40:2179.1 or a subsequently amended statute and any rules published pursuant to those statutes.

2. All direct care staff shall have the ability to read and write at a level that allows them to understand the client's services plan, document services provided, and carry out directions competently as assigned.

a. The training shall address needed areas of improvement, as determined by the worker's performance reviews, and may address the special needs of clients.

3. All direct care staff shall be trained in recognizing and responding to medical emergencies of clients.

G. Direct Care Staff Responsibilities. The direct care staff shall:

1. – 8. ...

9. be responsible for accurate daily documentation of services provided and status of clients to be reported on progress notes and/or progress reports.

H. Direct Care Staff Training

1. The provider shall ensure that each direct care staff, either contracted or employed, satisfactorily completes a minimum of 16 hours of training upon hire and before providing direct care and services to clients. Such training shall include the

following topics and shall be documented, maintained and readily available in the agency's records:

a. the provider's policies and procedures;

b. emergency and safety procedures;

c. recognizing and responding to medical emergencies including:

i. knowing when to make an immediate call to 911; and

ii. knowing how to support the client while waiting for the emergency personnel to arrive such as maintaining an open airway for breathing, checking for the presence of a pulse, or stopping bleeding, when needed;

d. client's rights;

e. detecting and reporting suspected abuse and neglect, utilizing the department's approved training curriculum;

f. reporting critical incidents;

g. universal precautions;

h. documentation;

i. implementing service plans;

j. confidentiality;

k. detecting signs of illness or impairment that warrant medical or nursing intervention;

l. basic skills required to meet the health needs and problems of the client;

m. the management of aggressive behavior, including acceptable and prohibited responses; and

n. scald prevention training.

2. The provider shall ensure that each direct care staff, either contracted or employed, satisfactorily completes a basic first aid course within 45 days of hire.

3. Training received by a direct care staff worker from previous employment with a HCBS agency is transferrable between HCBS agencies when the hiring HCBS agency:

a. obtains from the previous employer proof of the employee's successful documented completion of any required training; and

b. obtains documented evidence of the employee's continued competency of any required training received during employment with the previous HCBS provider.

I. Competency Evaluation

1. A competency evaluation shall be developed and conducted to ensure that, at a minimum, each direct care staff, either contracted or employed, is able to demonstrate competencies in the training areas in §5055.H.

2. Written or oral examinations shall be provided.

3. The examination shall reflect the content and emphasis of the training curriculum components in §5055.H and shall be developed in accordance with accepted educational principles.

4. The provider shall ensure that those direct care staff with limited literacy skills receive substitute examination sufficient to determine written reading comprehension and competency to perform duties assigned.

J. Continuing Education

1. Annually thereafter, the provider shall ensure that each direct care staff, either contracted or employed, satisfactorily completes a minimum of eight hours of training in order to ensure continuing competence. Orientation and normal supervision shall not be considered for meeting this requirement. This training shall address the special needs of clients and may address areas of employee weakness as determined by the direct care staff person's performance reviews.

J.1.a. – J.5.c. Repealed.

K. Volunteers/Student Interns

1. A provider utilizing volunteers or student interns on any regular basis shall have a written plan for using such resources. This plan shall be given to all volunteers and interns. The plan shall indicate that all volunteers and interns shall:

a. be directly supervised by a paid staff member;

b. be oriented and trained in the philosophy, policy and procedures of the provider, confidentiality requirements and the needs of clients;

c. have documentation of reference checks in accordance with facility policy;

d. – m. Repealed.

2. Volunteer/student interns shall be a supplement to staff employed by the provider but shall not provide direct care services to clients.

L. Direct Care Staff Supervisor. The HCBS provider shall designate and assign a direct care staff supervisor to monitor and supervise the direct care staff.

1. The supervisor shall be selected based upon the needs of the client outlined in the ISP.

2. A provider may have more than one direct care staff supervisor.

3. – 4. Repealed.

M. Direct Care Supervision

1. A direct care staff supervisor shall make an in-person supervisory visit of each direct care staff within 60 days of being hired or contracted and at least annually thereafter. Supervisory visits shall occur more frequently:

a. if dictated by the ISP;

b. as needed to address worker performance;

c. to address a client’s change in status; or

d. to assure services are provided in accordance with the ISP.

2. The supervisory visit shall be unannounced and utilized to evaluate:

a. the direct care staff person's ability to perform assigned duties;

b. whether services are being provided in accordance with the ISP; and

c. if goals are being met.

3. Documentation of supervision shall include:

a. the worker/client relationship;

b. services provided;

c. observations of the worker performing assigned duties;

d. instructions and comments given to the worker during the onsite visit; and

e. client satisfaction with service delivery.

4. An annual performance evaluation for each direct care staff person shall be documented in his/her personnel record.

5. In addition to the in-person supervisory visits conducted with direct care staff, the provider shall visit the home of each client on a quarterly basis to determine whether the individual:

a. service plan is adequate;

b. continues to need the services; and

c. service plan needs revision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:79 (January 2012), amended LR 40:1007 (May 2014), LR 41:2639 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5057. Client Records

A. Client records shall be accurately documented and maintained in the HCBS provider's office. Current progress notes shall be maintained at the home. The provider shall have a written record for each client which shall include:

A.1. – 6. ...

7. an accurate financial record of each client's personal funds which includes a written record of all of the financial transactions involving the personal funds of the client deposited with the provider;

a. the client (or his legal representative) shall be afforded access to such record; and

b. the financial records shall be available through quarterly statements;

c. Repealed.

8. – 11.a. ...

b. a description of any serious or life threatening medical condition(s); and

c. a description of any medical treatment or medication necessary for the treatment of any medical condition;

d. Repealed.

12. a copy of any signed and dated advance directive that has been provided to the HCBS provider, or any physician orders, signed and dated, relating to end of life care and services.

B. HCBS providers shall maintain client records for a period of no less than six years.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:82 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5059. Client Funds and Assets

A. The HCBS provider shall not require that the provider be the manager of the client’s funds and shall develop and implement written policies and procedures to protect client funds. Clients shall have the right to control their personal resources.

B. In the case of a representative payee, all social security rules and regulations shall be adhered to. The provider shall obtain written authorization from the client and/or his/her legal or responsible representative if they will be designated as the representative payee of the client’s social security payment.

C. If the provider manages a client’s personal funds, the provider shall furnish a written statement which includes the client's rights regarding personal funds, a list of the services

offered and charges, if any, to the client and/or his/her legal or responsible representative.

D. – E.6. ...

F. A client with a personal fund account managed by the HCBS provider may sign an account agreement acknowledging that any funds deposited into the personal account, by the client or on his/her behalf, are jointly owned by the client and his legal representative or next of kin. These funds do not include Social Security funds that are restricted by Social Security Administration (SSA) guidelines. The account agreement shall state that:

1. – 4. ...

5. the joint owner of a client's account shall not be an employee, either contracted or on staff, of the provider.

G. – H. ...

1. Upon the death of a client, the provider shall act accordingly upon any burial policies of the client.

2. ...

3. If a valid account agreement has been executed by the client, the provider shall transfer the funds in the client's personal fund account to the joint owner within 30 days of the client's death.

H.4. - I. ...

J. Burial Policies. Upon discharge of a client, the provider shall release any and all burial policies to the client or his/her legal or responsible representative.

K. Life Insurance Policies. An HCBS provider and/or its employee(s), either contracted or staff, shall not purchase a life insurance policy on an HCBS client and designate the provider and/or its employee(s) as the beneficiary of the policy.

L. The provisions of this section shall have no effect on federal or state tax obligations or liabilities of the deceased client's estate. If there are other laws or regulations which conflict with these provisions, those laws or regulations will govern over and supersede the conflicting provisions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:82 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5061. Quality Enhancement Plan

A. An HCBS provider shall develop, implement and maintain a quality enhancement (QE) plan that:

1. ensures that the provider is in compliance with federal, state, and local laws;

2. meets the needs of the provider's clients;

3. is attaining the goals and objectives established by the provider;

4. maintains systems to effectively identify issues that require quality monitoring, remediation and improvement activities;

5. improves individual client outcomes and individual client satisfaction;

6. includes plans of action to correct identified issues that:

a. monitor the effects of implemented changes; and

b. result in revisions to the action plan;

7. is updated on an ongoing basis to reflect changes, corrections and other modifications.

B. The QE plan shall include:

1. a process for identifying on a quarterly basis the risk factors that affect or may affect the health, safety and/or welfare of the clients of the HCBS provider receiving services, that includes, but is not limited to:

a. review and resolution of complaints;

b. review and resolution of incidents; and

c. incidents of abuse, neglect and exploitation;

2. a process to review and resolve individual client issues that are identified;

3. a process to review and develop action plans to resolve all system wide issues identified as a result of the processes above;

4. a process to correct problems that are identified through the program that actually or potentially affect the health and safety of the clients; and

5. a process of evaluation to identify or trigger further opportunities for improvement in identification of individual client care and service components.

C. The QE program shall hold bi-annual committee meetings to:

1. assess and choose which QE plan activities are necessary and set goals for the quarter;

2. evaluate the activities of the previous quarter; and

3. implement any changes that protect the clients from potential harm or injury.

D. The QE plan committee shall:

1. develop and implement the QE plan; and

2. report to the administrator any identified systemic problems.

E. The HCBS provider shall maintain documentation of the most recent 12 months of the QE plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:83 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5063. Emergency Preparedness

A. – A.9. ...

B. Providers shall ensure that each client has a documented individual plan in preparation for, and response to, emergencies and disasters and shall assist clients in identifying the specific resources available through family, friends, the neighborhood and the community.

C. Continuity of Operations. The provider shall have written disaster and emergency preparedness plans which are based on a risk assessment using an all hazards approach for both internal and external occurrences, developed and approved by the governing body and updated annually;

1. to maintain continuity of the provider's operations in preparation for, during and after an emergency or disaster;

2. to manage the consequences of all disasters or emergencies that disrupt the provider's ability to render care and treatment, or threaten the lives or safety of the clients; and

3. that are prepared in coordination with the provider's local and/or parish Office of Homeland Security and Emergency Preparedness (OHSEP) and include provisions for persons with disabilities.

D. The HCBS provider shall develop and implement policies and procedures based on the emergency plan, risk assessment, and communication plan which shall be reviewed and updated at least annually to maintain continuity of the agency's operations in preparation for, during and after an emergency or disaster. The plan shall be designed to manage the consequences of all hazards,

declared disasters or other emergencies that disrupt the provider's ability to render care and treatment, or threatens the lives or safety of the clients.

1. At any time that the HCBS provider has an interruption in services or a change in the licensed location due to an emergency situation, the provider shall notify HSS no later than the next business day.

2. – 6. Repealed.

E. The provider shall follow and execute its emergency preparedness plan in the event of the occurrence of a declared disaster or other emergency. The plan shall include, at a minimum:

1. provisions for the delivery of essential services to each client as identified in the individualized emergency plan for each client, whether the client is in a shelter or other location;

2. provisions for the management of staff, including provisions for adequate, qualified staff as well as for distribution and assignment of responsibilities and functions;

3. provisions for back-up staff;

4. the method that the provider will utilize in notifying the client's family or caregiver if the client is evacuated to another location either by the provider or with the assistance or knowledge of the provider. This notification shall include:

a. the date and approximate time that the provider or client is evacuating;

b. the place or location to which the client(s) is evacuating which includes the name, address and telephone numbers; and

c. a telephone number that the family or responsible representative may call for information regarding the provider's evacuation;

5. provisions for ensuring that sufficient supplies, medications, clothing and a copy of the individual service plan are sent with the client, if the client is evacuated; and

6. the procedure or methods that will be used to ensure that identification accompanies the individual. The identification shall include the following information:

a. current and active diagnoses;

b. medication(s), including dosages and times administered;

c. allergies;

d. special dietary needs or restrictions; and

e. next of kin, including contact information.

F. – H. ...

I. All agency employees, either contracted or staff, shall be trained in emergency or disaster preparedness. Training shall include orientation, ongoing training and participation in planned drills for all personnel.

J. – J.5. ...

K. – K.7. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:83 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

Subchapter G. Adult Day Care Module

§5071. General Provisions

A. ...

B. An ADC program shall provide services for 10 or more functionally impaired adults who are not related to the owner or operator of the HCBS provider.

1. For the purposes of this Section, "*functionally impaired adult*" shall be defined as individuals 17 years of age or older who are physically, mentally or socially impaired to a degree that requires supervision.

C. The following two programs shall be provided under the ADC Module:

1. Day Habilitation Services

a. Day habilitation services include assistance with acquisition, retention or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting separate from the recipient's private residence or other residential living arrangement. Day habilitation services provide activities and environments designed to foster the

acquisition of skills, appropriate behavior, greater independence and personal choice.

i. Day habilitation services are provided in a variety of community settings, (i.e. local recreation department, garden clubs, libraries, etc.) other than the recipient's residence and are not limited to a fixed-site facility.

b. Services are furnished to a client who is 17 years of age or older and has a developmental disability, or who is a functionally impaired adult, on a regularly scheduled basis during normal daytime working hours for one or more days per week, or as specified in the recipient's service plan.

c. Day habilitation services focus on enabling the recipient to attain or maintain his or her maximum functional level, and shall be coordinated with any physical, occupational, or speech therapies in the service plan. These services may also serve to reinforce skills or lessons taught in other settings.

2. Prevocational Services

a. Prevocational services prepare a recipient for paid employment or volunteer opportunities. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Services are not job-task oriented, but are aimed at a generalized result. These services are reflected in the recipient's service plan and are directed to habilitative (e.g. attention span, motor skills) rather than explicit employment objectives.

b. Individuals receiving prevocational services shall have an employment related goal as part of their individual service plan.

c. This service is not available to clients eligible to receive services under a program funded under the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA).

D. When applying for the ADC module under the HCBS provider license, the provider shall indicate whether it is providing day habilitation, prevocational/employment-related services or both.

D.1. – E. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:85 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5073. Operational Requirements for ADC Facilities

A. The client/staff ratio in an ADC facility shall be a minimum of one staff person per eight clients, unless additional staff coverage is needed to meet the needs of the client, as specified in the service plan.

B. - C. ...

1. If meals are prepared by the facility or contracted from an outside source, the following conditions shall be met:

a. menus shall be written in advance and shall provide for a variety of nutritional foods from which a client may choose;

C.1.b. - C.3. ...

4. Dining areas shall be adequately equipped with tables, chairs, eating utensils and dishes designed to meet the functional needs of clients. Clients shall have choice of where and with whom to eat within the ADC facility.

C.5. – D.2. ...

3. Sufficient supervision/training shall be provided where potentially harmful materials such as cleaning solvents and/or detergents are used.

4. – 5. ...

6. Fire drills shall be performed at least once a quarter. Documentation of performance shall be maintained.

E. – E.8. ...

a. The ratio of bathrooms to number of clients shall meet the requirements in accordance with applicable state and/or federal laws, rules and regulations.

b. Individuals shall be ensured privacy when using bathroom facilities.

c. – 11. ...

12. The building in which the ADC is located shall meet the requirements of the OSFM in accordance with applicable state and federal laws, rules and regulations.

F. – F.1. ...

a. The provider shall maintain full financial records of clients' earnings if the facility pays the client.

b. ...

c. The provider shall have a current U.S. Department of Labor Sub-Minimum Wage Certificate if the provider pays sub-minimum wage.

2. ...

3. Clients shall be directly supervised when operating any type of power driven equipment such as lawn mowers or electrical saws, unless:

a. – b. ...

c. sufficient training is given to the recipient and the training is documented.

4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:85 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

Subchapter H. Family Support Module

§5075. General Provisions

A. ...

B. Services covered by the family support module may include:

1. special equipment;

2. limited adaptive housing;

3. medical expenses and medications;

4. nutritional consultation and regime;

5. related transportation;

6. special clothing;

7. special therapies;

8. respite care;

9. dental care; and

10. family training and therapy.

C. – C.10. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:86 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

Subchapter I. Personal Care Attendant Module

§5079. General Provisions

A. ...

B. Personal care attendant services may include:

1. – 1.i. ...

j. any non-complex medical task which can be delegated;

2. assistance and/or training in the performance of tasks in accordance with the plan of care and related to:

2.a. – 3. ...

4. support and assistance in developing relationships with neighbors and others in the community; and

5. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:87 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

Subchapter J. Respite Care

§5083. General Provisions

A. ...

B. Respite care may be provided as an in-home or center-based service. The services may be provided in the client's home or in a licensed respite center.

C. Providers of in-home respite care services must comply with:

1. all HCBS providers core licensing requirements;

2. PCA module specific requirements; and

3. the respite care services module in-home requirements.

D. Providers of center-based respite care services shall comply with:

1. ...

2. respite care services module in-home requirements; and

3. the respite care services module center-based requirements.

E. When applying for the respite care service module under the HCBS provider license, the provider shall indicate whether it is providing in-home respite care, center-based respite care or both.

E.1. – F. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:87 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5085. Operational Requirements for In-Home Respite Care

A. – A.2. ...

B. In-home respite care service providers shall have sufficient administrative, support, professional and direct care staff to meet the needs of clients at all times.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:88 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5087. Operational Requirements for Center-Based Respite Care

A. – A.2. ...

a. The provider shall ensure that the client has an adequate supply of clothing, needed personal care supplies, and medications, if needed.

A.3. – B.1.a. ...

2. Arrangements for medical isolation shall be available. The provider shall inform the family to move the client to isolation when medically determined as necessary.

3. Medication shall be prescribed only by a licensed health care practitioner in accordance with the individual's professional licensing laws.

C. ...

1. Planning, preparation and serving of foods shall be in accordance with the nutritional, social, emotional and medical needs of the clients. The menu shall include a minimum of three varied, nutritious and palatable meals a day plus nourishing snacks.

2. All milk and milk products used for drinking shall be Grade A and pasteurized.

3. There shall be no more than 14 hours between the last meal or snack offered on one day and the first meal offered of the following day.

C.4. – C.5. Repealed.

D. – F.1. ....

2. If it has been determined either medically or legally that the best interests of the client necessitate restrictions on communications or visits, these restrictions shall be documented in the service plan.

F.3. – G.1. ...

2. All bedrooms shall be on or above street grade level and be outside rooms. Bedrooms shall accommodate no more than four residents. Bedrooms shall provide at least 60 square feet per person in multiple sleeping rooms and not less than 80 square feet in single rooms.

3. ...

4. There shall be separate and gender segregated sleeping rooms for adults and for adolescents. When possible, there should be individual sleeping rooms for clients whose behavior would be disruptive to other clients.

5. Appropriate furniture shall be provided including but not limited to, a chest of drawers, a table or desk, an individual closet with clothes racks and shelves accessible to the residents.

G.6. – H.7. ...

I. There shall be a designated space for dining. Dining room tables and chairs shall be adjusted in height to suit the ages and physical needs of the clients.

J. – K. ...

1. The facility shall comply with all applicable federal, state and local building codes, fire and safety laws, ordinances and regulations.

2. Secure railings shall be provided for flights of more than four steps and for all porches more than four feet from the ground.

3. Where clients under age two are in care, secure safety gates shall be provided at the head and foot of each flight of stairs accessible to these clients.

4. Before swimming pools are made available for client use, written documentation shall be received by LDH-OPH confirming that the pool meets the requirements of the Virginia Graeme Baker Pool and Spa Safety Act of 2007 or, in lieu of, written documentation confirming that the pool meets the requirements of ANSI/APSP-7 (2006 Edition) which is entitled the "American National Standard for Suction Entrapment Avoidance in Swimming Pools, Wading pools, Spas, Hot Tubs and Catch Basins."

a. ...

b. An individual, 18 years of age or older, shall be on duty when clients are swimming in ponds, lakes or pools where a lifeguard is not on duty. The facility shall have staff sufficient

in number certified in water safety by the American Red Cross or other qualified certifying agency to meet the needs of the clients served.

c. The provider shall have written plans and procedures for water safety.

d. The provider shall have available water safety devices sufficient in number for clients served and staff trained in the proper usage of such devices.

5. Storage closets or chests containing medicine or poisons shall be kept securely locked.

6. Garden tools, knives and other potentially dangerous instruments shall be inaccessible to clients without supervision.

K.7. – L.4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:88 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

Subchapter K. Substitute Family Care Module

§5089. General Provisions

A. – A.2. ...

B. Substitute family care services are delivered by a principal caregiver, in the caregiver's home, under the oversight and management of a licensed SFC provider.

1. The SFC caregiver is responsible for providing the client with a supportive family atmosphere in which the availability, quality and continuity of services are appropriate to the age, capabilities, health conditions and special needs of the individual.

2. The licensed SFC provider shall not be allowed to serve as the SFC caregiver.

C. Potential clients of the SFC program shall meet the following criteria:

1. have a developmental disability as defined in R.S. 28:451.1-455.2 of the Louisiana Developmental Disability Law or its successor statute;

2. be at least 18 years of age;

a. Repealed.

3. have an assessment and service plan pursuant to the requirements of the HCBS provider licensing rule.

a. The assessment and service plan shall assure that the individual's health, safety and welfare needs can be met in the SFC setting.

4. – 4.a. Repealed.

D. SFC Caregiver Qualifications

1. An SFC caregiver shall be certified by the SFC provider before any clients are served. In order to be certified, the SFC caregiver applicant shall:

a. undergo a professional home study conducted by the provider;

b. participate in all required orientations, trainings, monitoring and corrective actions required by the SFC provider; and

c. meet all of the caregiver specific requirements of this section.

2. The personal qualifications required for certification include:

a. Residency. The caregiver shall reside in the state of Louisiana and shall provide SFC services in the caregiver's home. The caregiver's home shall be located in the state of Louisiana and in the region in which the SFC provider is licensed.

b. Criminal Record and Background Clearance. Members of the SFC caregiver's household shall not have any felony convictions. Other persons approved to provide care or supervision of the SFC client for the SFC caregiver shall not have any felony convictions.

i. Prior to certification, the SFC caregiver, all members of the SFC caregiver applicant's household and persons approved to provide care or supervision of the SFC client on a regular or intermittent basis, shall undergo a statewide criminal record background check conducted by the Louisiana State Police, or its authorized agent.

ii. Annually thereafter, the SFC caregiver, all members of the SFC caregiver applicant's household and persons approved to provide care or supervision of the SFC client on a regular or intermittent basis, shall have criminal record background checks.

c. Age. The SFC principal caregiver shall be at least 21 years of age. Maximum age of the SFC principal caregiver shall be relevant only as it affects his/her ability to provide for the SFC client as determined by the SFC provider through the home assessment. The record shall contain proof of age.

3. The SFC caregiver may be either single or married. Evidence of marital status shall be filed in the SFC provider's records and shall include a copy of legal documents adequate to verify marital status.

4. The SFC caregiver is not prohibited from employment outside the home or from conducting a business in the home provided that:

a. the SFC home shall not be licensed as another healthcare provider;

b. such employment or business activities do not interfere with the care of the client;

c. such employment or business activities do not interfere with the responsibilities of the SFC caregiver to the client;

d. a pre-approved, written plan for supervision of the participant which identifies adequate supervision for the participant is in place; and

e. the plan for supervision is signed by both the SFC caregiver and the administrator or designee of the SFC provider.

E. The SFC caregiver shall not be certified as a foster care parent(s) for the Department of Child and Family Services (DCFS) while serving as a caregiver for a licensed SFC provider.

1. The SFC provider, administrator or designee shall request confirmation from DCFS that the SFC caregiver applicant is not presently participating as a foster care parent and document this communication in the SFC provider's case record.

2. – 3.a. Repealed.

F. In addition to the discharge criteria in the core requirements, the client shall be discharged from the SFC program upon the client meeting any of the following criteria:

1. incarceration or placement under the jurisdiction of penal authorities or courts for more than 30 days;

a. – c. Repealed.

2. lives in or changes his/her residence to another region in Louisiana or another state;

a. – c. Repealed.

3. admission to an acute care hospital, rehabilitation hospital, intermediate care facility for persons with intellectual

disabilities (ICF/ID) or nursing facility with the intent to stay longer than 90 consecutive days;

4. the client and/or his legally responsible party(s) fails to cooperate in the development or continuation of the service planning process or service delivery;

a. – e. Repealed.

5. a determination is made that the client's health and safety cannot be assured in the SFC setting; or

6. failure to participate in SFC services for 30 consecutive days for any reason other than admission to an acute care hospital, rehabilitation hospital, ICF/ID facility or nursing facility.

G. – H.6. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:89 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5090. Operational Requirements for Substitute Family Care Providers

A. - A.1.a. ...

2. Within the first 90 days following the client's move into the home, the SFC provider shall provide and document training to the SFC caregiver(s) inclusive of the following:

a. – d. ...

3. Annually, the SFC provider shall provide the following training to the SFC caregiver:

a. six hours of training related to the client's needs and interests including the client's specific priorities and preferences; and

b. six hours of training on issues of health and safety such as the identification and reporting of allegations of abuse, neglect or exploitation and misappropriation of client's funds.

A.4. – B. ...

1. The SFC provider shall conduct no less than monthly face to face reviews of each SFC caregiver and/or household in order to:

B.1.a. – C. ...

1. 24-hour care and supervision, including provisions for:

a. a flexible routine that includes client's choices or preferences;

C.1.b. – D. ...

1. SFC Providers shall ensure that the SFC caregiver complies with the following standards for client records that are maintained in the SFC's home.

a. – c. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:90 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5091. Operational Requirements for Substitute Family Care Caregivers

A. The SFC caregiver(s) shall provide environments that meet the needs of the clients.

B. The SFC caregiver's home shall be located within a 25 mile radius of community facilities, resources and services such as medical care, schools, recreation facilities, churches and other community facilities.

C. The home of the SFC family shall not be used as lodging for any person(s) who is not subject to the prior approval certification process of the SFC family. The SFC family shall notify the administrator, or designee of the SFC provider, of any person(s) allowed to reside in the home following the initial certification.

1. ...

2. All persons residing with the SFC family, including temporary or on a non-permanent basis, shall undergo statewide criminal record background checks conducted by the Louisiana State Police, or its authorized agent.

C.3. – D. ...

E. The SFC caregiver shall have a stable income sufficient to meet routine expenses, independent of the payments for their substitute family care services, as demonstrated by a reasonable comparison between income and expenses conducted by the administrator or designee of the SFC provider upon initiation of services and as necessary thereafter.

F. The SFC caregiver shall have a plan that outlines in detail the supports to be provided. This plan shall be approved and updated as required and as necessary by the SFC provider. The SFC caregiver shall allow only SFC approved persons to provide care or supervision to the SFC client.

1. ...

a. identification of any person(s) who will supervise the participant on a routine basis which shall be prior approved by the administrator or designee of the SFC agency provider;

F.1.b. – H. ...

1. The home of the SFC caregiver shall be safe and in good repair, comparable to other family homes in the neighborhood. The home and its exterior shall be free from materials and objects which constitute a potential for danger to the individual(s) who reside in the home.

2. SFC homes featuring either a swimming or wading pool shall ensure that safety precautions prevent unsupervised accessibility to clients.

3. - 3.f. ...

g. household first aid supplies to treat minor injuries;

h. plumbing in functional working order and availability of a method to maintain safe water temperatures for bathing; and

H.3.i. – H.5. ...

a. There shall be a bedroom for each client with at least 80 square feet exclusive of closets, vestibules and bathrooms and equipped with a door, that locks from the inside for privacy unless contraindicated by any condition of the client. Clients shall be afforded privacy within their sleeping units.

H.5.a.i. – I.2.c. ...

d. documentation of a driver's license status inquiry report on each family member who will be transporting the client.

3. If the client(s) are authorized to operate the family vehicle, liability insurance coverage specific to the client(s) use shall be maintained at all times in accordance with state law.

J. – J.1.k. ...

i. Repealed.

J.1.l. – J.3.c. ...

K. – K.2. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:91 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

Subchapter L. Supervised Independent Living Module

§5093. General Provisions

A. – B. ...

C. Clients receiving SIL services shall be at least 18 years of age. An SIL living situation is created when an SIL client utilizes an apartment, house or other single living unit as his place of residence.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:93 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5094. Operational Requirements for the Supervised Independent Living Module

A. A provider shall ensure that the living situation is freely selected by the client from among non-disability specific settings. An SIL residence may be owned or leased by either the provider or the client. At the expense of the owner or lessee, a provider shall ensure that the living situation shall be:

1. - 4. ...

5. a living situation that affords the client's individual privacy, including the ability to lock entrance doors;

6. - 9. ...

10. equipped with an efficiency bedroom space or a separate private bedroom with a door that locks from the inside for privacy, if not contraindicated by a condition of the client residing in the room:

10.a. – 15.g. ...

16. equipped with functional smoke detectors and a fire extinguisher.

B. A provider shall ensure that any client placed in the living situation has:

1. ...

2. access to transportation;

3. access to any services in the client's approved ISP; and

4. privacy within their living and sleeping units.

C. The department shall have the right to inspect the SIL and client's living situation as deemed necessary.

D. – E. ...

1. For purposes of this Section, a supervisor is defined as a person, so designated by the provider agency, due to experience and expertise relating to needs of clients with developmental disabilities.

2. A supervisor shall have a minimum of two documented contacts per week with the client. The weekly contacts may be made by telephone, adaptive communication technology or other alternative means of communication. There shall be documentation of what was discussed with the client and any outcomes.

a. The supervisor shall have a minimum of one face-to-face contact per month with the client in the client's home. The frequency of the face-to-face contacts shall be based on the client's needs. There shall be documentation of what was discussed with the client and any outcomes.

2.b. – 3. ...

F. In addition to the core licensing requirements, the SIL provider shall:

1. – 2. ...

3. assure that bill payment is completed timely in accordance with the individual service plan, if applicable; and

F.4. – G.8. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:93 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5095. Supervised Independent Living Shared Living Conversion Process

A. ...

B. Only an existing ICF/ID group or community home with up to eight beds may voluntarily and permanently close its home and its related licensed, Medicaid certified and enrolled ICF/ID beds to convert to new community-based waiver opportunities (slots) for up to six persons in shared living model or in combination with other ROW residential options. These shared living models will be located in the community.

1. ...

C. The LDH Office for Citizens with Developmental Disabilities (OCDD) shall approve all individuals who may be admitted to live in and to receive services in an SIL Shared Living Conversion model.

D. The ICF/ID provider who wishes to convert an ICF/ID to an SIL via the shared living conversion model shall be approved by OCDD and shall be licensed by HSS prior to providing services in this setting, and prior to accepting any ROW participant or applicant for residential or any other developmental disability service(s).

E. An ICF/ID provider who elects to convert to an SIL via the shared living conversion model may convert to one or more conversion models, provided that the total number of SIL shared living conversion slots; beds shall not exceed the number of Medicaid facility need review bed approvals of the ICFs/ID so converted.

1. The conversion of an ICFs/ID to an SIL via the shared living conversion process may be granted only for the number of beds

specified in the applicant's SIL shared living conversion model application to OCDD.

2. ...

3. Any remaining Medicaid facility need review bed approvals associated with an ICF/ID that is being converted cannot be sold or transferred and are automatically considered terminated.

F. An ICF/ID provider who elects to convert to an SIL via the shared living conversion process shall obtain the approval of all of the residents of the home(s) (or the responsible parties for these residents) regarding the conversion of the ICF/ID prior to beginning the process of conversion.

G. Application Process

1. The ICF/ID owner or governing board must sign a conversion agreement with OCDD regarding the specific beds to be converted and submit a plan for the conversion of these beds into ROW shared living or other ROW residential waiver opportunities, along with a copy of the corresponding and current ICF/ID license(s) issued by HSS.

a. This conversion plan shall be approved and signed by OCDD and the owner or signatory of the governing board prior to the submittal of a HCBS provider, SIL module licensing application to LDH-HSS.

2. A licensed and certified ICF/ID provider who elects to convert an ICF/ID to an SIL via the shared living conversion process shall submit a licensing application for a HCBS provider

license, SIL Module. The ICF/ID applicant seeking to convert shall submit the following information with his licensing application:

a. – b. ...

i. that the license to operate an ICF/ID will be voluntarily surrendered upon successfully completing an initial licensing survey and becoming licensed as an SIL via the shared living conversion process; and

ii. that the ICF/ID Medicaid facility need review bed approvals will be terminated upon the satisfactory review of the conversion as determined by OCDD, pursuant to its 90 day post conversion site visit; and

3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:94 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

Subchapter M. Supported Employment Module

§5099. General Provisions

A. ...

1. return all telephone calls from clients within one business day, other than during working hours;

2. – 3. ...

4. have licensed nursing services staff and direct care staff;

A.5. – B. ...

C. The assessment of needs shall be done prior to placement of the client on a job site. A Medicaid HCBS comprehensive assessment approved by a LDH program office for a Medicaid recipient shall not substitute for the assessment of needs. A comprehensive plan of care approved by the department for Medicaid or waiver reimbursement shall not substitute for the ISP.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:95 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

Chapter 51. Home and Community-Based Services Providers

Subchapter A. Monitored In-Home Caregiving Module

§5101. General Provisions

A. – A.2. ...

B. Providers applying for the monitored in-home caregiving module under the HCBS license shall meet the core licensing requirements (except those set forth in §5005.B.4, §5005.C.ii and §5007.F.1.c) and the module specific requirements of this Section.

C. During any survey or investigation of the HCBS provider with the MIHC module conducted by the LDH-HSS, the survey process

begins once the surveyor enters either the client's place of residence or the provider's licensed place of business. When the survey begins at the client's residence, the provider shall transmit any records requested by the HSS surveyor within two hours of such request to the location as designated by the HSS surveyor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2639 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5103. Staffing Requirements, Qualifications, and Duties

A. – E.3. ...

F. Care Manager Responsibilities. The following responsibilities of the care manager for the MIHC module shall substitute for the requirements in §5055.L and §5055.M. The responsibilities of the MIHC care manager shall include:

F.1. – G.2.a. ...

b. have a statewide criminal background check conducted by the Louisiana State Police, or its authorized agent, in accordance with the applicable state laws;

c. ...

d. be at least 18 years of age;

G.2.e. – H.5. ...

6. providing ongoing supervision of health-related activities, including, but not limited to:

a. reminding the client to take prescribed medications;

b. – h.v. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2639 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§5105. Operational Requirements for Monitored In-Home Caregiving

A. Training. The following requirements for training and competency for the MIHC module shall substitute for the training and competency requirements in §5055.H, §5055.I, and §5055.J.

A.1. – C.5. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2641 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing
and
Office for Citizens with Developmental Disabilities

Home and Community-Based Services Waivers
Children's Choice Waiver
Allocation of Waiver Opportunities
(LAC 50:XXI.Chapter 111, 11303, Chapters 115-119, and 12301)

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:XXI.Chapters 111-117, §11905 and §12301, and repealed §§11901 and 11903 under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950, et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community-Based Services Waivers
Subpart 9. Children's Choice

Chapter 111. General Provisions

§11101. Introduction

A. The Children's Choice (CC) Waiver is a home and community-based services (HCBS) program that offers supplemental support to individuals with intellectual/developmental disabilities (IDD) who currently live in the community or who will leave an institution to return to the community.

B. The Children's Choice Waiver is an option offered to individuals who have been determined eligible for developmental disability services and are on the intellectual/developmental disabilities request for services registry (IDDRFSR) hereafter referred to as "the registry" or as identified in §11105 or §11107.

C. Children's Choice Waiver participants are eligible for all medically necessary Medicaid services in addition to Children's Choice Waiver services.

D. The number of participants in the Children's Choice Waiver is contingent upon available funding.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 26:2793 (December 2000), repromulgated for LAC, LR 28:1983 (September 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 35:1891 (September 2009), LR 39:2497 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

§11103. Participant Qualifications and Admissions Criteria

A. The Children's Choice Waiver is available to individuals

who:

1. are from birth through age 20;

2. ...

3. are on the registry unless otherwise specified in §11105 and §11107;

4. ...

5. meet the requirements for an intermediate care facility for persons with intellectual/developmental disabilities (ICF/ID) level of care, which requires active treatment of a developmental disability under the supervision of a qualified developmental disability professional;

A.6. - B. ...

C. Participants who are currently receiving Children's Choice Waiver services who reach their eighteenth birthday and remain enrolled in school may continue receiving Children's Choice Waiver services until their twenty-first birthday at which time they will transition to the most appropriate OCDD adult waiver as long as they remain eligible for waiver services.

D. Participants who are currently receiving Children's Choice Waiver services and reach their eighteenth birthday and choose to no longer attend school may transition to a Supports Waiver anytime between their eighteenth birthday and their twenty-first birthday based on a person-centered planning process.

1. Participants who transition to a Supports Waiver will continue receiving Supports Waiver services after their twenty-first birthday as long as they remain eligible for waiver services.

2. Children's Choice Waiver recipients who reach their twenty-first birthday will transfer into the most appropriate OCDD adult waiver as long as they remain eligible for waiver services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 35:1892 (September 2009), amended LR 39:2498 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

§11104. Admission Denial or Discharge Criteria

A. Individuals shall be denied admission to or discharged from the Children's Choice Waiver if one of the following criteria is met:

1. ...

2. the individual does not meet the requirements for ICF/ID level of care;

3. - 4. ...

5. the participant is admitted to an ICF/ID or nursing facility with the intent to stay and not to return to waiver

services:

a. ...

b. The participant will be discharged from the waiver on the ninety-first day if the participant is still in the ICF/ID or nursing facility.

6. - 7. ...

8. - 8.c. Repealed.

B. Recipients of the Children's Choice Waiver who reach their twenty-first birthday will transfer to the most appropriate OCDD adult waiver as long as they remain eligible for waiver services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2498 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

§11105. Money Follows the Person Rebalancing Demonstration

A. The Money Follows the Person (MFP) Rebalancing Demonstration is a federal demonstration program awarded by the Centers for Medicare & Medicaid Services to the department. The demonstration is a transition program that targets individuals using

qualified institutional services and moves them to home and community-based long-term care services. The MFP Rebalancing Demonstration will stop allocation of opportunities when the demonstration expires.

1. ...

B. Individuals must meet the following criteria for participation in the MFP Rebalancing Demonstration.

1. Individuals with a developmental disability must:

a. be from birth through 20 years of age;

1.b. - 2. ...

C. Individuals who participate in the demonstration are not required to have a protected request date on the registry.

D. - E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 35:1892 (September 2009), amended by Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

§11107. Allocation of Waiver Opportunities

A. The intellectual/developmental disabilities (I/DD) request

for services registry, hereafter referred to as "the registry," shall be used to identify individuals with intellectual and/or developmental disabilities who are waiting for an OCDD waiver opportunity.

1. - 1.b. Repealed.

B. Individuals who are found eligible for developmental disabilities services according to the *OCDD System Entry Policy*, and who request waiver services will be added to the registry. The request for services registry is arranged by the urgency of need and date of application for developmentally disabled (DD) waiver services.

1. - 1.b. Repealed.

C. Children's Choice Waiver opportunities shall be offered to individuals under the age of 21 who are on the registry, have the highest level of need and the earliest registry date. These individuals shall be notified in writing when a funded Children's Choice waiver opportunity is available and that he/she is next in line for a Children's Choice waiver slot except for allocations to the specific targeted groups cited as follows:

1. Money Follows the Person Rebalancing Demonstration Waiver opportunities which are allocated to demonstration participants only. The MFP Rebalancing Demonstration will stop allocation of opportunities when the demonstration expires. An additional 20

Children's Choice waiver opportunities shall be created for the MFP Rebalancing Demonstration Program and must only be filled by a demonstration participant. No alternate may utilize an MFP Rebalancing Demonstration opportunity.

a. In the event that an MFP Rebalancing Demonstration opportunity is vacated or closed, the opportunity will be returned to the MFP Rebalancing Demonstration pool and an offer will be made based upon the approved program guidelines until such time as the demonstration expires.

1.b. - 6. Repealed.

D. The Office for Citizens with Developmental Disabilities (OCDD) has the responsibility to monitor the utilization of Children's Choice Waiver opportunities. At the discretion of the OCDD, specifically allocated waiver opportunities may be reallocated to better meet the needs of individuals with developmental disabilities.

E. Funded opportunities will only be allocated to individuals who successfully complete the financial eligibility and medical certification process required for waiver certification.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for

Citizens with Developmental Disabilities, LR 35:1892 (September 2009), amended LR 40:539, 540 (March 2014), LR 41: 125 (January 2015),amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

Chapter 113. Service

§11303. Service Definitions

A. The services in this §11303 are included in the service package for the Children's Choice Waiver. All services must be included on the approved plan of care which prior authorizes all services.

A.1. – N.4.a. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1871 (September 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, amended LR 36:324 (February 2010), LR 39:2498 (September 2013), LR 40:67 (January 2014), LR 41:126 (January 2015), amended by Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

Chapter 115. Provider Participation Requirements

Subchapter B. Provider Requirements

§11521. General Requirements for Medicaid Enrollment

A. ...

1. The provider must meet all the requirements for licensure as established by state laws and rules promulgated by the Department of Health (LDH) or have a current, valid license or certification from the appropriate governing board for that profession.

2. - 3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 27: 310 (March 2001), repromulgated for LAC, LR 28:1984 (September 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2501 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

§11523. Enrollment

A. ...

B. Providers shall attend all mandated meetings and training

sessions as directed by OCDD as a condition of enrollment and continued participation as waiver providers. Attendance at a provider enrollment orientation shall be required prior to enrollment as a Medicaid provider of services. The frequency of the provider enrollment orientations shall be determined by LDH Health Standards Section.

C. A separate provider enrollment packet must be completed for each site in each LDH administrative region where the agency will provide services.

D. Participant case records and billing records shall be housed at the site in LDH administrative region where the participant resides.

E. - F. ...

G. Providers shall participate in initial training for prior authorization and data collection. This initial training and any LDH scheduled subsequent training addressing program changes is to be provided at no cost to the agency. Repeat training must be paid for by the requesting agency.

H. Providers shall develop a quality improvement plan which must be submitted for approval within 60 days after LDH training. Self-assessments are due six months after approval of the plan and yearly thereafter.

I. - N. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 27:310 (March 2001), repromulgated for LAC by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1984 (September 2002), amended LR 28:2533 (December 2002), repromulgated LR 29:38 (January 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2501 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

§11525. Case Management Providers

A. ...

1. Providers of case management services for the Children's Choice program must have a contract with LDH to provide services to waiver participants.

2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services

Financing, LR 27:310 (March 2001), repromulgated for LAC, LR 28:1985 (September 2002), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

§11527. Direct Service Providers

A. ...

1. The provider must be licensed by LDH as a home and community-based services provider and meet the module specific requirements for the services being provided.

2. Direct service providers must provide, at a minimum, family support services, crisis support services and subcontract services for center-based respite, family training, environmental adaptations and specialized medical equipment and supplies.

3. The following services may either be provided directly by the direct service provider or by written agreement (subcontract) with other agents; and the actual provider of the service, whether it is the direct service provider or a subcontracted agent, shall meet the following licensure or other qualifications:

a. Center-based respite must be provided by a facility licensed by LDH and meet all module specific requirements for the service.

3.b. - 5. ...

6. Agencies must provide services consistent with the

personal outcomes identified by the participant and his/her family.

7. All personnel who are at a supervisory level must have a minimum of one year verifiable work experience in planning and providing direct services to people with intellectual/developmental disabilities.

8. - 12. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 27: 310 (March 2001), repromulgated for LAC, LR 28:1985 (September 2002), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1872 (September 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2501 (September 2013), LR 41:127 (January 2015), repromulgated LR 41:538 (March 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

Chapter 117. Crisis Provisions

§11701. Participation in Children's Choice

A. Children's Choice Waiver participants who experience a

crisis that increases the need for paid supports to a level that cannot be accommodated within the service cap specified in §11301.A on waiver expenditures, may request consideration for a crisis designation. A *crisis* is defined as a catastrophic change in circumstances rendering the natural and community support system unable to provide for the health and welfare of the participant at the level of benefits offered under Children's Choice. The procedure in this Chapter has been developed to address these situations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 27:1015 (July 2001), repromulgated for LAC, LR 28:1986 (September 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2502 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

§11703. Crisis Designation Criteria

A. In order to be considered a crisis, one of the following circumstances must exist:

1. - 2. ...

3. the participant is committed to the custody of LDH by

the court; or

4. ...

5. the participant's condition deteriorates to the point when the plan of care is inadequate.

B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 27:1015 (July 2001), repromulgated for LAC, LR 28:1986 (September 2002), amended LR 29:704 (May 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2503 (September 2013), LR 41:128 (January 2015, amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

§11705. Crisis Extension Provisions

A. Additional services (crisis support) outside of the waiver cap amount shall be approved by the OCDD state office. Crisis designation is time-limited, depending on the anticipated duration of the causative event. Each request for crisis designation may be approved for a maximum of three months.

B. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 27:1015 (July 2001), repromulgated for LAC, LR 28:1986 (September 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2503 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

Chapter 119. Noncrisis Provisions

§11901. General Provisions

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1465 (June 2002), repromulgated for LAC, LR 28:1986 (September 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2503 (September 2013), LR 41:128 (January 2015), repealed by the Department of Health, Bureau of

Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

§11903. Good Cause

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1465 (June 2002), repromulgated for LAC, LR 28:1986 (September 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2503 (September 2013), repealed by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

§11905. Determination Responsibilities and Appeals

A. The LGE shall have the responsibility for making the determinations as to the matters set forth in this Chapter 119. Persons who have elected or whose legal representatives have elected that they receive services under the Children's Choice Waiver have the right to appeal any determination of the department as to matters set forth in this Chapter 119, under the regulations and procedures applicable to Medicaid fair hearings.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254

and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, Bureau of Health Services Financing, LR 28:1987 (September 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2504 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

Chapter 123. Self-Direction Initiative

§12301. Self-Direction Service Delivery Option

A. ...

B. Participant Responsibilities. Waiver participants choosing the self-directed service delivery option must understand the rights, risks and responsibilities of managing their own care and individual budget. If the participant is under 18 years of age or is unable to make decisions independently, the participant must have an authorized representative who understands the rights, risks and responsibilities of managing his/her care and supports within the participant's individual budget. The employer must be at least 18 years of age. Responsibilities of the participant or authorized representative include:

1. completion of mandatory trainings, including the

rights and responsibilities of managing services, supports and individual budgets;

2. ...

a. adhering to the health and welfare safeguards identified by the team, including the application of a comprehensive monitoring strategy and risk assessment and management systems;

3. participation in the development and management of the approved budget:

a. this annual budget is determined by the recommended service hours listed in the participant's plan of care to meet his/her needs; and

b. the participant's individual budget includes a potential amount of dollars within which the participant or his/her authorized representative exercises decision-making responsibility concerning the selection of services and service providers;

c. Repealed.

4. all services rendered shall be prior approved and in accordance with the plan of care; and

5. all services must be documented in service notes, which describes the services rendered and progress towards the participant's personal outcomes and plan of care.

C. ...

1. Voluntary Termination. The waiver participant may

choose at any time to withdraw from the self-direction service delivery option and return to the traditional provider agency management of services.

2. - 2.d.iv. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2504 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing
and
Office for Citizens with Developmental Disabilities

Home and Community-Based Services Waivers
New Opportunities Waiver
Allocation of Waiver Opportunities
(LAC 50:XXI.Chapter 137)

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:XXI.Chapter 137 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community-Based Services Waivers
Subpart 11. New Opportunities Waiver

Chapter 137. General Provisions

§13703. Participant Qualifications and Admissions Criteria

A. In order to qualify for a New Opportunities Waiver (NOW), an individual must be 21 years of age or older and meet all of the following criteria:

1. have an intellectual and/or developmental disability as specified in R.S. 28:451.2;

2. be deemed eligible for developmental disability services and be on the intellectual/developmental disabilities

(IDD) request for services registry (RFSR), unless otherwise specified through programmatic allocation in §13707;

3. – 5. ...

6. have justification, based on a uniform needs-based assessment and a person-centered planning discussion that the NOW is the only OCDD Waiver that will meet the needs of the individual;

7. ...

8. be a citizen of the United States or a qualified immigrant.

B. Individuals under the age of 21 who receive NOW services prior to promulgation of this final Rule will be grandfathered-in to the NOW program. Individuals under the age of 21 who are transitioning to NOW services within 90 days of promulgation of this final Rule will retain their NOW offer and be allowed to transition to the NOW program.

C. Individuals age 18 through 20 may be offered a funded NOW opportunity if the results of the uniform needs-based assessment and person-centered planning discussion determine that the NOW is the most appropriate waiver. These offers must be approved by the OCDD assistant secretary/designee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1201 (June 2004), amended by the

Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:96 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

§13704. Needs-Based Assessment

A. A uniform needs-based assessment in conjunction with person-centered planning is utilized in the service planning process for the individuals receiving or participating in an OCDD waiver. The results of this assessment activity shall be utilized to determine which OCDD waiver will be offered to the individual during the initial plan of care process.

1. The participant or his/her representative may request a reconsideration and present supporting documentation if he/she disagrees with the specific OCDD waiver offered as a result of the needs based assessment and person-centered planning process. If the participant disagrees with the reconsideration decision, he/she may request a fair hearing through the formal appeals process.

2. – 4. Repealed.

B. The needs-based assessment instrument(s) is designed to evaluate the practical support requirements of individuals with developmental disabilities in daily living, medical and behavioral areas, including:

1. home living;

2. community living;

3. lifelong learning;

4. employment;

5. health and safety;

6. social activities; and

7. protection and advocacy.

C. The needs-based assessment instrument(s) is also used to evaluate the individual's support needs based on information and data obtained from four areas of the person's life, which includes:

1. support needs measurements including:

a. material support;

b. vision related supports;

c. hearing related supports;

d. supports for communicating needs;

e. positive behavior supports;

f. physicians supports;

g. professional supports (e.g., registered nurse, physical therapist, occupational therapist, etc.); and

h. stress and risk factors;

2. living arrangements and program participation including:

a. people living in the home;

b. natural supports in the home;

c. living environments; and

d. supports and service providers;

3. medical and diagnostic information findings including:

a. diagnoses;

b. medications and dosages; and

c. need for relief from pain or illness; and

4. personal satisfaction reports including:

a. agency supports provided at home;

b. work or day programs;

c. living environment;

d. family relationships; and

e. social relationships.

D. – D.4.e. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing and the Office for Citizens with Developmental Disabilities, LR 36:65 (January 2010), amended LR 40:69 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

§13706. Resource Allocation

A. The resource allocation model shall be used to assign service units based on the findings of the needs-based assessment and person-centered planning discussion for individuals who will be offered or are currently receiving New Opportunities Waiver services. Within the resource allocation

model, there is a determination of an acuity level for individual and family support (IFS) services.

1. The participant or his/her representative may request a reconsideration and present supporting documentation if he/she disagrees with the amount of assigned IFS service units. If the participant disagrees with the reconsideration decision, he/she may request a fair hearing through the formal appeals process.

2. Implementation of the resource allocation model was phased-in for the allocation of new NOW opportunities and renewal of existing NOW opportunities beginning July 1, 2009.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Service Financing and the Office for Citizens with Developmental Disabilities, LR 43:

§13707. Programmatic Allocation of Waiver Opportunities

A. The intellectual/developmental disabilities request for services registry, hereafter referred to as "the registry," shall be used to identify persons with intellectual and/or developmental disabilities who are waiting for an OCDD waiver opportunity.

B. Individuals who are found eligible for developmental disabilities services using standardized tools, and who request waiver services will be added to the registry. The request for services registry (RFSR) is arranged by the urgency of need and

date of application for developmentally disabled (DD) waiver services.

C. Funded OCDD waiver opportunities will be offered based on the following priority groups:

1. Individuals living at Pinecrest Supports and Services Center or in a publicly operated ICF-ID when it was transitioned to a private ICF-ID through a cooperative endeavor agreement, or their alternates. *Alternates* are defined as individuals living in a private ICF-ID who will give up the private ICF-ID bed to an individual living at Pinecrest or to an individual who was living in a publicly operated ICF-ID when it was transitioned to a private ICF-ID through a cooperative endeavor agreement. Individuals requesting to transition from either facility listed above are awarded the appropriate waiver when one is requested, and their health and safety can be assured in an OCDD home and community-based waiver program:

a. the bed being vacated by the alternate in the private ICF-ID must be reserved for 14 days for the placement of a person being discharged from a publicly-operated facility. The person's discharge from a publicly-operated facility and his/her subsequent placement in a private ICF-ID is to occur as close as possible to the actual discharge of the alternate from the private ICF-ID and is not to exceed 14 days from the date of the alternate's discharge and certification for the waiver. The bed may be held vacant beyond the 14 days with the concurrence of the private ICF-ID provider;

b. the funded waiver opportunity will be reserved for a period not to exceed 120 days, however this 120-day period may be extended as needed;

2. individuals on the registry who have the highest level of need and the earliest registry date shall be notified in writing when a funded OCDD waiver opportunity is available and that he/she is next in line to be evaluated for a possible waiver assignment.

3. – 8. Repealed.

D. ...

E. Funded waiver opportunities will only be allocated to individuals who successfully complete the financial and medical eligibility process required for waiver certification.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 31:2900 (November 2005), amended LR 33:2440 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 37:3526 (December 2011), LR 40:70 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

§13709. Emergency Opportunities

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 31:2901 (November 2005), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:71 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 42:1520 (September 2016), repealed by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing
and
Office for Citizens with Developmental Disabilities

Home and Community-Based Services Waivers
Residential Options Waiver
Allocation of Waiver Opportunities
(LAC 50:XXI.16105,16107, and 16901)

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:XXI.16105, §16107, and §16901 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community Based Services Waivers
Subpart 13. Residential Options Waiver

Chapter 161. General Provisions

§16105. Participant Qualifications

A. In order to qualify for Residential Options Waiver (ROW), an individual must be 21 years of age or older and meet all of the following criteria:

1. have an intellectual and/or developmental disability as specified in R.S. 28:451.2;

2. be determined eligible through the developmental disabilities entry process;

3. be on the intellectual/developmental disabilities (IDD) request for services registry (RFSR), unless otherwise specified through programmatic allocation in §16107;

4. meet the requirements for an ICF/ID level of care which requires active treatment for developmental disabilities under the supervision of a qualified developmental disabilities professional;

5. meet the financial eligibility requirements for the Louisiana Medicaid Program;

6. have justification, based on a uniform needs-based assessment and a person-centered planning discussion that the ROW is the OCDD waiver that will meet the needs of the individual;

7. be a resident of Louisiana; and

8. be a citizen of the United States or a qualified alien.

B. Individuals under the age of 21 who receive ROW services prior to promulgation of this final Rule will be grandfathered-in to the ROW program. Individuals under the age of 21 who are in the process of being certified into the ROW prior to the promulgation of this final Rule will retain their ROW offer and be allowed to transition to the ROW program.

C. Individuals age 18 through 20 may be offered a funded ROW opportunity if the results of the uniform needs-based assessment and person-centered planning discussion determine

that the ROW is the most appropriate waiver. These offers must be approved by the OCDD assistant secretary/designee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2441 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2155 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

§16107. Programmatic Allocation of Waiver Opportunities

A. The intellectual/developmental disabilities request for services registry, hereafter referred to as "the registry," shall be used to identify persons with intellectual and/or developmental disabilities who are waiting for an OCDD waiver opportunity. Individuals who are found eligible for developmental disabilities services using standardized tools, and who request waiver services will be added to the registry. The request for services registry (RFSR) is arranged by urgency of need and date of application for developmentally disabled (DD) waiver services, except for the priority groups listed in B.1-4 of this Section.

1. – 3. Repealed.

B. Funded OCDD waiver opportunities will be offered based on the following priority groups:

1. Individuals with intellectual and developmental disabilities (I/DD) who have a statement of approval (SOA) through OCDD, and who currently receive services via the Office of Aging and Adult Services (OAAS) Community Choices Waiver (CCW) or Adult Day Health Care (ADHC) Waiver programs, shall be a priority group to allow for an one time transition into the ROW upon promulgation of this final Rule.

2. Individuals living at Pinecrest Supports and Services Center or in a publicly operated ICF-ID when it was transitioned to a private ICF-ID through a cooperative endeavor agreement, or their alternates. Alternates are defined as individuals living in a private ICF-ID who will give up the private ICF-ID bed to an individual living at Pinecrest or to an individual who was living in a publicly operated ICF-ID when it was transitioned to a private ICF-ID through a cooperative endeavor agreement. Individuals requesting to transition from either facility listed above are awarded the appropriate waiver when one is requested, and their health and safety can be assured in an OCDD home and community-based waiver program.

a. – b.vii. Repealed.

3. Individuals on the registry who have the highest level of need and the earliest registry date shall be notified in writing when a funded OCDD waiver opportunity is available

and that he/she is next in line to be evaluated for a possible waiver assignment.

a. – e. Repealed.

4. Persons who reside in a Medicaid-enrolled ICF/ID and wish to transition to a home and community-based residential services waiver through a voluntary ICF/ID bed conversion process.

5. – 7. Repealed.

C. ...

D. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2441 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2155 (October 2015), LR 42:62 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

Chapter 169. Reimbursement

§16901. Unit of Reimbursement

A. Reimbursement for the following services shall be a prospective flat rate for each approved unit of service provided

to the waiver participant. One quarter hour (15 minutes) is the standard unit of service and reimbursement shall not be made for less than one quarter hour of service. This covers both the service provision and administrative costs for these services:

1. – 5.f. ...

6. supported employment;

a. individual placement; and

b. micro-enterprise; and

7. adult day health care.

7.a. – 8. Repealed.

EXCEPTION: The reimbursement for support coordination shall be at a fixed monthly rate and in accordance with the terms of the established contract.

B. – J. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2456 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:1049 (April 2013), LR 41:2168, 2170 (October 2015), LR 42:63 (January 2016), LR 42:900 (June 2016), amended by the Department of Health, Bureau of Health Services Financing

and the Office for Citizens with Developmental Disabilities, LR 43:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing
and
Office for Citizens with Developmental Disabilities

Home and Community-Based Services Waivers
Supports Waiver
Allocation of Waiver Opportunities
(LAC 50:XXI.5301, 5501, 5505, 5701, 5901)

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:XXI.5301, §5501, §5701, and §5901 and adopted §5505 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950, et seq.

Title 50
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XXI. Home and Community Based Services Waivers
Subpart 5. Supports Waiver

Chapter 53. General Provisions

§5301. Purpose

A. - A.3. ...

B. Allocation of Waiver Opportunities. The intellectual/developmental disabilities request for services registry, hereafter referred to as "the registry," shall be used to identify persons with intellectual and/or developmental

disabilities who are waiting for an OCDD waiver opportunity.

1. Individuals who are found eligible for developmental disabilities services using standardized tools, and who request waiver services will be added to the registry.

2. The request for services registry (RFSR) is arranged by the urgency of need and date of application for developmentally disabled (DD) waiver services.

3. Funded OCDD waiver opportunities will be offered based on the following two priority groups:

a. Individuals living at Pinecrest Supports and Services Center or in a publicly operated ICF-ID when it was transitioned to a private ICF-ID through a cooperative endeavor agreement, or their alternates. Alternates are defined as individuals living in a private ICF-ID who will give up the private ICF-DD bed to an individual living at Pinecrest or to an individual who was living in a publicly operated ICF-ID when it was transitioned to a private ICF-ID through a cooperative endeavor agreement. Individuals requesting to transition from either facility listed above are awarded the appropriate waiver when one is requested, and their health and safety can be assured in an OCDD home and community-based waiver program.

i. The bed being vacated by the alternate in the private ICF-ID must be reserved for 14 days for the placement of a person being discharged from a publicly-operated

facility. The person's discharge from a publicly-operated facility and his/her subsequent placement in a private ICF-ID is to occur as close as possible to the actual discharge of the alternate from the private ICF-ID and is not to exceed 14 days from the date of the alternate's discharge and certification for the waiver. The bed may be held vacant beyond the 14 days with the concurrence of the private ICF-ID provider.

ii. The funded waiver opportunity will be reserved for a period not to exceed 120 days. However, this 120-day period may be extended as needed.

b. Individuals on the registry who have the highest level of need and the earliest registry date shall be notified in writing when a funded OCDD waiver opportunity is available and that he/she is next in line to be evaluated for a possible waiver assignment.

C. The Office for Citizens with Development Disabilities has the responsibility to monitor the utilization of Supports Waiver opportunities. At the discretion of OCDD, specifically allocated waiver opportunities may be reallocated to better meet the needs of citizens with developmental disabilities in the state of Louisiana.

D. Funded waiver opportunities will only be allocated to individuals who successfully complete the financial and medical eligibility process required for waiver certification.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1604 (September 2006), amended LR 40:2583 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

Chapter 55. Target Population

§5501. Participant Qualifications and Admissions Criteria

A. - A.8. ...

B. - F. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1604 (September 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:2583 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

§5505. Needs-Based Assessment

A. A uniform needs-based assessment in conjunction with person-centered planning is utilized in the service planning process for the individuals receiving or participating in an OCDD waiver. The results of this assessment activity shall be utilized to determine which OCDD waiver will be offered to the individual during the initial plan of care process.

1. The participant or his/her representative may request a reconsideration and present supporting documentation if he/she disagrees with the specific OCDD waiver offered as a result of the needs-based assessment and person-centered planning process. If the participant disagrees with the reconsideration decision, he/she may request a fair hearing through the formal appeals process.

B. The needs-based assessment instrument(s) is designed to evaluate the practical support requirements of individuals with developmental disabilities in daily living, medical and behavioral areas including:

1. home living;

2. community living;

3. lifelong learning;

4. employment;

5. health and safety;

6. social activities; and

7. protection and advocacy.

C. The needs-based assessment instrument(s) is also used to evaluate the individual's support needs based on information and data obtained from the following four areas of the person's life:

1. support needs scale measurements including:

a. material supports;

b. vision related supports;

c. hearing related supports;

d. supports for communicating needs;

e. positive behavior supports;

f. physicians supports;

g. professional supports (e.g., registered nurse, physical therapist, occupational therapist, etc.); and

h. stress and risk factors;

2. living arrangements and program participation including:

a. people living in the home;

b. natural supports in the home;

c. living environments; and

d. supports and service providers;

3. medical and diagnostic information findings including:

a. diagnoses;

b. medications and dosages; and

c. need for relief from pain or illness;

4. personal satisfaction reports including:

a. agency supports provided at home;

b. work or day programs;

c. living environment;

d. family relationships; and

e. social relationships.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

Chapter 57. Covered Services

§5701. Supported Employment Services

A. - G.4. ...

H. Restrictions. Participants receiving individual supported employment services may also receive prevocational or day habilitation services. However, these services cannot be provided during the same service hours and cannot total more than five hours of services in the same day. Participants receiving group supported employment services may also receive prevocational or day habilitation services; however, these services cannot be provided in the same service day.

I. - J. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1605 (September 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:2585 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

Chapter 59. Provider Participation

§5901. General Provisions

A. - C.1. ...

2. Supported Employment Services. The provider must possess a valid certificate of compliance as a community rehabilitation provider (CRP) from Louisiana rehabilitation services or the certification and training as required per OCDD.

3. - 6. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1607 (September 2006), LR

34:662 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, Office for Citizens with Developmental Disabilities, LR 40:2587 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Inpatient Hospital Services
Non-Rural, Non-State Hospitals
Reimbursement Rate Increase
(LAC 50:V.Chapter 9)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:V.Chapter 9 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 1. Inpatient Hospital Services

Chapter 9. Non-Rural, Non-State Hospitals

Subchapter B. Reimbursement Methodology

§953. Acute Care Hospitals

A. – U.1. ...

V. Effective for dates of service on or after January 1, 2018, the inpatient per diem rate paid to acute care hospitals shall be increased by indexing to 56 percent of the small rural hospital prospective per diem rate in effect on January 1, 2017.

1. Acute care hospitals whose per diem rates as of January 1, 2017, excluding the graduate medical education portion of the per diem, are greater than 56 percent of the

January 1, 2017 small rural hospital rate shall not be increased.

2. Carve-out specialty units, nursery boarder, and well-baby services are excluded from these rate increases.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:876 (May 2008), amended LR 34:877 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1895, 1896 (September 2009), repromulgated LR 35:2182 (October 2009), amended LR 36:1552 (July 2010), LR 36:2561 (November 2010), LR 37:2161 (July 2011), LR 39:3095 (November 2013), LR 39:3297 (December 2013), LR 40:312 (February 2014), repromulgated LR 40:1939, 1940 (October 2014), LR 41:133 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:963 (May 2017), amended LR 43:1389 (July 2017), amended LR 43:

§955. Long-Term Hospitals

A. - K. ...

L. Effective for dates of service on or after January 1, 2018, the inpatient per diem rate paid to long term hospitals shall be increased by indexing to 42 percent of the small rural hospital prospective per diem rate in effect on January 1, 2017. Long term hospitals whose per diem rates as of January 1, 2017,

excluding the graduate medical education portion of the per diem, are greater than 42 percent of the January 1, 2017 small rural hospital rate shall not be increased.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR: 34:876 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1895 (September 2009), amended LR 36:1554 (July 2010), LR 36:2562 (November 2010), LR 37:2162 (July 2011), LR 40:312 (February 2014), repromulgated LR 40:1940 (October 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:964 (May 2017), amended LR 43:

§959. Inpatient Psychiatric Hospital Services

A. – M.1. ...

N. Effective for dates of service on or after January 1, 2018, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals, and distinct part psychiatric units within non-rural, non-state acute care hospitals, shall be increased by indexing to 31 percent of the small rural hospital prospective per diem rate in effect on January 1, 2017.

1. Psychiatric hospitals and units whose per diem rates as of January 1, 2017, excluding the graduate medical

education portion of the per diem, are greater than 31 percent of the January 1, 2017 small rural hospital rate shall not be increased.

2. Inpatient hospital psychiatric services provided under a public-private partnership as defined in §959.L of this Chapter, LAC 50:V.1701 and LAC 50:V.2901 shall be exempt from this rate increase.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:876 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1895 (September 2009), amended LR 36:1554 (July 2010), LR 36:2562 (November 2010), LR 37:2162 (July 2011), LR 39:94 (January 2013), LR 39:323 (February 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 43:964 (May 2017), amended LR 43:

§961. Inpatient Rehabilitation Hospital Services

A. Definitions

Free-Standing Rehabilitation Hospital-a non-rural, non-state hospital that is designated as a rehabilitation specialty hospital by Medicare.

B. Reimbursement Methodology

1. Effective for dates of service on or after January 1, 2018, the prospective per diem rate paid to non-rural, non-state free-standing rehabilitation hospitals shall be indexed to 36 percent of the small rural hospital prospective per diem rate in effect on January 1, 2017.

2. Rehabilitation hospitals whose per diem rates as of January 1, 2017, excluding the graduate medical education portion of the per diem, are greater than 36 percent of the January 1, 2017 small rural hospital rate shall not be increased.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Medicaid Eligibility
Express Lane Eligibility
(LAC 50:III.1103)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:III.1103 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part III. Eligibility
Subpart 1. General Administration

Chapter 11. Express Lane Eligibility

§1103. Eligibility Determinations

A. – A.1. ...

B. The department shall utilize eligibility findings from express lane agencies that administer the:

1. ...

2. Temporary Assistance for Needy Families;

3. state program funded under title IV-D (child support enforcement services/SES);and

4. Child Care and Development Block Grant Act of 1990.

5. - 7. Repealed.

C. – D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1555 (July 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Outpatient Hospital Services
Non-Rural, Non-State Hospitals and Children's Specialty Hospitals
Reimbursement Rate Increase
(LAC 50:V.5313, 5317, 5513, 5517, 5713, 5517, 5713. 5719, 6115 and 6119)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:V.5313, §5317, §5513, §5517, §5713, §5517, §5719, §6115 and §6119 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part V. Hospitals
Subpart 5. Outpatient Hospitals

Chapter 53. Outpatient Surgery

Subchapter B. Reimbursement Methodology

§5313. Non-Rural, Non-State Hospitals

A. – I.1. ...

J. Effective for dates of service on or after January 1, 2018, the reimbursement rates paid to non-rural, non-state hospitals for outpatient surgery shall be increased by 4.82 percent of the rates on file as of December 31, 2017.

1. Hospitals participating in public-private

partnerships as defined in §6701 shall be exempted from this rate increase.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2041 (September 2010), LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:964 (May 2017), LR 43:

§5317. Children's Specialty Hospitals

A. – G.1. ...

H. Effective for dates of service on or after January 1, 2018, the reimbursement paid to children's specialty hospitals for outpatient surgery shall be increased by 4.82 percent of the rates on file as of December 31, 2017.

1. Final reimbursement shall be 92.15 percent of allowable cost as calculated through the cost report settlement process.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2042 (September 2010), amended LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of

Health Services Financing, LR 43:965 (May 2017), LR 43:

Chapter 55. Clinic Services

Subchapter B. Reimbursement Methodology

§5513. Non-Rural, Non-State Hospitals

A. – I.1. ...

J. Effective for dates of service on or after January 1, 2018, the reimbursement rates paid to non-rural, non-state hospitals for outpatient clinic services shall be increased by 4.82 percent of the rates on file as of December 31, 2017.

1. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2042 (September 2010), LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:

§5517. Children's Specialty Hospitals

A. – G. ...

H. Effective for dates of service on or after January 1, 2018, the reimbursement rates paid to children's specialty hospitals for outpatient hospital clinic services shall be

increased by 4.82 percent of the rates on file as of December 31, 2017.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2042 (September 2010), amended LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:

Chapter 57. Laboratory Services

Subchapter B. Reimbursement Methodology

§5713. Non-Rural, Non-State Hospitals

A. – I.1. ...

J. Effective for dates of service on or after January 1, 2018, the reimbursement rates paid to non-rural, non-state hospitals for outpatient laboratory services shall be increased by 4.82 percent of the rates on file as of December 31, 2017.

1. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2042

(September 2010), LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:

§5719. Children's Specialty Hospitals

A. – G. ...

H. Effective for dates of service on or after January 1, 2018, the reimbursement rates paid to children's specialty hospitals for outpatient clinical diagnostic laboratory services shall be increased by 4.82 percent of the rates on file as of December 31, 2017.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2043 (September 2010), amended LR 37:3267 (November 2011), LR 40:314 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:

Chapter 61. Other Outpatient Hospital Services

Subchapter B. Reimbursement Methodology

§6115. Non-Rural, Non-State Hospitals

A. – I.1. ...

J. Effective for dates of service on or after January 1, 2018, the reimbursement rates paid to non-rural, non-state hospitals for outpatient hospital services, other than clinical diagnostic laboratory services, outpatient surgeries,

rehabilitation services and outpatient hospital facility fees shall be increased by 4.82 percent of the rates in effect as of December 31, 2017.

1. Final reimbursement shall be 74.56 percent of allowable cost as calculated through the cost report settlement process.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2043 (September 2010), LR 37:3267 (November 2011), LR 40:314 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:

§6119. Children's Specialty Hospitals

A. – G.1. ...

H. Effective for dates of service on or after January 1, 2018, the reimbursement fees paid to children's specialty hospitals for outpatient hospital services, other than rehabilitation services and outpatient hospital facility fees, shall be increased by 4.82 percent of the rates in effect as of December 31, 2017.

1. Final reimbursement shall be 92.15 percent of allowable cost as calculated through the cost report settlement process.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2044 (September 2010), amended LR 37:3267 (November 2011), LR 40:314 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:

Rebekah E. Gee MD, MPH

Secretary