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
(LAC 50:XXI.Chapters 161, 163, 165, 167, and 169)

The Department of Health, Bureau of Health Services Financing and Office for Citizens with Developmental Disabilities has amended LAC 50:XXI.Subpart 13 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. 40:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community-Based Services Waivers
Subpart 13. Residential Options Waiver

Chapter 161. General Provisions

§16101. Introduction

A. The Residential Options Waiver (ROW), a 1915(c) home and community-based services (HCBS) waiver, is designed to assist beneficiaries in leading healthy, independent and productive lives to the fullest extent possible and promote the full exercise of their rights as citizens of the state of Louisiana. Services are provided with the goal of promoting independence through strengthening the participant’s capacity

for self-care and self-sufficiency. The ROW is person-centered incorporating the beneficiary's support needs and preferences with a goal of integrating the beneficiary into their community. The ROW provides opportunities for eligible individuals with developmental disabilities to receive HCBS services that allow them to transition to and/or remain in the community. These individuals would otherwise require an intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care.

B. ...

C. This program is not intended to provide continuous 24 hours a day, one-to-one supports.

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 41:2154 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1764 (December 2019), LR 47:1507 (October 2021), LR 48:1558 (June 2022), LR 50:

§16103. Program Description

A. The ROW is designed to utilize the principles of self-determination and to supplement the family and/or community supports that are available to maintain the individual in the community and are designed to allow an individual experience that mirrors the experiences of individuals without disabilities. These services are not to be restrictive, but liberating, by empowering individuals to experience life in the most fulfilling manner as defined by the individual while still assuring health and safety. In keeping with the principles of self-determination, ROW includes a self-direction option, which allows for greater flexibility in hiring, training, and general service delivery issues. ROW services are meant to enhance, not replace, existing informal networks.

B. – B.3. ...

C. ROW services are accessed through a single point of entry in the human services district or authority, referred to as local governing entities (LGE). All waiver beneficiaries choose their support coordination and direct service provider agencies through the freedom of choice process.

C.1. – E.3. ...

4. If it is determined that the ROW can no longer meet the beneficiary’s health and safety needs and/or support

the beneficiary, the support coordination agency will conduct person-centered discovery activities.

E.5. – F. ...

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 41:2154 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1764 (December 2019), LR 47:1507 (October 2021), LR 48:1559 (June 2022), LR 50:

§16106. Money Follows the Person Rebalancing Demonstration

A. – B. ...

1. Individuals with a developmental disability must:

a. occupy a licensed, approved Medicaid enrolled nursing facility, hospital, or ICF/IID bed for at least 60 days; and

1.b. – 2. ...

C. Individuals in the demonstration are not required to have a protected date on the intellectual/developmental disabilities request for services registry (RFSR).

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 41:2155 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1508 (October 2021), LR 48:1559 (June 2022), LR 50:

§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 individuals 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 registry is arranged by urgency of need and date of application for developmentally disabled (DD) waiver services.

B. OCDD operates on a tiered waiver approach for services delivery. If an individual's needs cannot be met with the initial waiver, they may request to be moved up to the next waiver in the tiers. The Residential Options Waiver (ROW) is the second tier within the OCDD tiered waiver process. ROW opportunities shall be offered based on the following groups.

1. Individuals living at publicly operated ICF/IID or who lived at a publicly operated ICF/IID when it was transitioned to a private ICF/IID through a cooperative endeavor agreement (CEA) facility, or their alternates. Alternates are defined as individuals living in a private ICF/IID who will give up the private ICF/IID bed to an individual living at a publicly operated ICF/IID or to an individual who was living in a publicly operated ICF/IID when it was transitioned to a private ICF/IID through a CEA facility.

2. Individuals requesting to transition from a publicly operated ICF/IID are awarded a slot when one is requested, and their health and safety can be assured in an OCDD waiver. This also applies to individuals who were residing in a publicly operated facility at the time the facility was privatized and became a CEA facility.

3. Individuals on the registry who have a current unmet need as defined by a screening of urgency need (SUN) score of urgent (3) or emergent (4) and the earliest registry date,

shall be notified in writing when a funded OCDD waiver opportunity is available and a waiver offer is available.

4. Individuals transitioning from ICF/IID facilities utilizing ROW conversion.

5. Transition of eligible individuals with a statement of eligibility (SOA) for intellectual developmental disability services in either the Office of Aging and Adult Services (OAAS) Community Choices Waiver (CCW) or OAAS Adult Day Health Care (ADHC) Waiver to enter the OCDD tiered waiver process for ROW services.

C. ...

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 43:2530 (December 2017), LR 45:1764 (December 2019), LR 47:1508 (October 2021), LR 50:

§16109. Admission, Denial or Discharge Criteria

A. Admission to the ROW shall be denied if one of the following criteria is met:

1. the individual does not meet the requirements for an ICF/IID level of care;

2. Repealed.

3. the individual does not meet developmental disability system eligibility;

4. the individual is incarcerated or under the jurisdiction of penal authorities, courts, or state juvenile authorities;

5. the individual resides in another state;

6. the health and welfare of the individual cannot be assured through the provision of ROW services;

7. the individual fails to cooperate in the eligibility determination process or in the development of the plan of care (POC); or

A.8. – B. ...

1. loss of Medicaid financial eligibility as determined by the Medicaid program;

2. – 10. ...

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 33:2443 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2156 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1765 (December 2019), LR 47:1509 (October 2021), LR 48:1560 (June 2022), LR 50:

Chapter 163. Covered Services

§16301. Assistive Technology and Specialized Medical Equipment and Supplies

A. – A.1.e. ...

2. This service also includes medically necessary durable and non-durable equipment not available under the Medicaid State Plan and repairs to such items, and equipment necessary to increase/maintain the independence and well-being of the beneficiary.

a. All equipment, accessories and supplies must meet all applicable manufacture, design, and installation requirements.

b. The services under the ROW are limited to additional services not otherwise covered under the Medicaid State Plan.

3. ...

4. This service includes necessary medical supplies not available under the Medicaid State Plan.

5. Prior to the beneficiary receiving any assistive technology device, a rehabilitation professional (including, but not limited to, an occupational therapist, speech therapist, and/or a physical therapist) must complete an evaluation. The therapist must assess the need and the type of device necessary to address the beneficiary's identified needs, and will make a recommendation for the specific assistive technology device. Assistive technology/specialized medical equipment must be included in the beneficiary's POC.

B. Assistive technology/specialized medical equipment (AT/SME) services provided through the ROW include the following:

1. the evaluation of assistive technology needs of a beneficiary, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the beneficiary in the customary environment of the beneficiary;

2. – 4. ...

5. training or technical assistance, on the use for the beneficiary, or where appropriate, family members, guardians, advocates, responsible representatives of the beneficiary, professionals, or others;

6. – 7. ...

a. separate payment will be made for repairs after expiration of the warranty only when it is determined to be cost effective;

8. services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for beneficiaries;

9. technology supports with remote features that may include, but are not limited to, mobile emergency response system, medication reminder system, monitoring device, the purchase of emergency response system and other equipment used to support someone remotely; and

a. remote technology service delivery covers monthly response center/remote support monitoring fee and technology upkeep (no internet cost coverage).

b. remote technology consultation is the evaluation of technology support needs for an individual identified in the POC if necessary;

10. incontinence briefs and supplies are available for a beneficiary, 21 years or older, who has a physician’s order and requires the use of incontinence briefs and supplies.

a. Service Restrictions

i. This service is for those who are 21 years of age or older.

ii. This service requires a physician’s order.

b. Service Limitations

i. The cost cannot exceed $2,500 in a single POC year.

C. – D. ...

E. Service Exclusions and Limitations

1. – 2. ...

3. For adults over the age of 20 years, specialized wheelchairs, whether mobile or travel, are covered under the State Plan durable medical equipment (DME) benefit, at any age, and are, therefore, not covered under the ROW.

4. Incontinence supplies annual maximum cost is $2,500 per POC year, without exception.

F. Provider Participation Requirements. Providers of AT/SMES services must meet the following participation requirements. The provider must:

1. ...

2. provide documentation on manufacturer’s letterhead that the agency listed on the Louisiana Medicaid Enrollment Form and Addendum (PE-50) is:

a. ...

b. has training and experience with the application, use, fitting, and repair of the equipment or devices they propose to sell or repair; and

3. upon completion of the work and prior to payment, the provider shall give the beneficiary a certificate of warranty for all labor and installation and all warranty certificates.

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HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2443 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2156 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1509 (October 2021), LR 48:1560 (June 2022), LR 50:

§16303. Community Living Supports

A. – C. ...

1. Services are not allowed to be provided in the direct service worker’s place of residence.

D. Community living supports may be shared by up to three beneficiaries who may or may not live together, and who have a

common direct service provider agency. In order for CLS services to be shared, the following conditions must be met:

1. an agreement must be reached among all of the involved beneficiaries, or their legal guardians, regarding the provisions of shared CLS services. If the person has a legal guardian, their approval must also be obtained. In addition, CLS direct support staff may be shared across the Children's Choice or New Opportunities Waiver at the same time;

2. the health and welfare must be assured for each beneficiary;

3. each beneficiary's plan of care must reflect shared services and include the shared rate for the service indicated;

4. a shared rate must be billed; and

5. ...

E. Service Exclusions

1. – 4.c. ...

5. Community living supports may not be billed at the same time on the same day as:

a. – b. ...

c. respite care services—out of home;

d. transportation—community access;

e. monitored in-home caregiving (MIHC); or

f. adult day health care.

g. Repealed.

6. Community living supports is not intended to provide continuous 24 hours a day one-to-one supports.

F. ...

1. Family members who provide CLS services must meet the same standards as providers who are unrelated to the beneficiary. Service hours shall be capped at 40 hours per week/per staff member, Sunday to Saturday, for services delivered by family members living in the home.

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 for Citizens with Developmental Disabilities, LR 33:2443 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2157 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1765 (December 2019), LR 47:1510 (October 2021), LR 48:1561 (June 2022), LR 50:

§16305. Companion Care

A. – E.1. ...

F. Service Exclusions

1. – 2. ...

3. Legally responsible individuals and legal guardians may provide companion care services for a beneficiary provided that the care is extraordinary in comparison to that of a beneficiary of the same age without a disability and the care is in the best interest of the beneficiary.

F.4. – G. ...

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 33:2444 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2158 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1765 (December 2019), LR 47:1511 (October 2021), LR 48:1561 (June 2022), LR 50:

§16307. Day Habilitation Services

A. Day habilitation services assist the beneficiary to gain desired community living experience, including the acquisition, retention, or improvement in self-help,

socialization, and adaptive skills, and/or to provide the beneficiary an opportunity to contribute to his or her community. These services shall be coordinated with any physical, occupational, or speech therapies identified in the individualized plan of care (POC). Day habilitation services may include assistance with personal care or with activities of daily living, but such assistance should not be the primary activity. Day habilitation services may serve to reinforce skills or lessons taught in other settings. Volunteer activities may be a part of this service and should follow the state guidelines for volunteering.

B.1. Day habilitation is the overarching service and may be delivered in a combination with these two service types:

a. onsite day habilitation; and

b. community life engagement.

2. Day habilitation services may be delivered virtually and be included in the plan of care.

C. ...

1. Transportation is a separate billable service and may be billed on the day that an in-person day habilitation service is provided.

2. Transportation is not a part of the service for virtual day habilitation.

D. Beneficiaries receiving day habilitation provider services may receive other services on the same day, but these services cannot be provided during the same time period, with the exception of community life engagement development and MIHC.

1. – 2. Repealed.

E. Service Exclusions

1. Time spent in transportation between the beneficiary's residence/location and the day habilitation site is not to be included in the total number of day habilitation service hours per day, except when the transportation is for the purpose of travel training.

a. Travel training for the purpose of teaching the beneficiary to use transportation services may be included in determining the total number of service hours provided per day. Travel training must be included in the beneficiary's POC.

2. Transportation-community access will not be used to transport ROW beneficiaries to any day habilitation services.

3. Day habilitation services cannot be billed for at the same time on the same day as:

a. community-living supports;

b. professional services, except when there are direct contacts needed in the development of a support plan;

c. respite—out of home;

d. adult day health care;

e. monitored in-home caregiving (MIHC);

f. prevocational services; or

g. supported employment.

4. Day habilitation services shall be furnished on a regularly scheduled basis for up to eight hours per day, one or more days per week.

a. Services are based on a 15 minute unit of service on time spent at the service site by the beneficiary. Any time less than 15 minutes of service is not billable or payable. No rounding up of units is allowed.

b. Services are based on the person-centered plan and the beneficiary’s ROW budget.

5. All virtual day habilitation services must be approved on the plan of care.

6. Day habilitation may not provide for the payment of services that are vocational in nature. For example, the primary purpose of producing goods or performing services.

F. Provider Qualifications. Providers must be licensed by the Department of Health as a home and community-based services provider and meet the module requirements for adult day care in LAC 48:I.Chapter 50.

F.1. – G. 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 33:2445 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2158 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1765 (December 2019), LR 47:1512 (October 2021), LR 48:1562 (June 2022), LR 50:

§16309. Dental Services

A. Dental services are available to adult beneficiaries over the age of 21 as a component of the ROW. Covered dental services include:

A.1. – C. ...

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 33:2445 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2159 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and

the Office for Citizens with Developmental Disabilities, LR 47:1512 (October 2021), LR 48:1563 (June 2022), LR 50:

§16311. Environmental Accessibility Adaptations

A. – C.2. ...

D. Modifications may be applied to rental or leased property only with the written approval from the landlord and approval from OCDD.

E. All environmental accessibility adaptations to a home or to a vehicle must meet all applicable standards of manufacture, design, and installation.

F. Service Exclusions for Home Adaptations

1. – 3.a. ...

4. Home modifications may not include modifications to the home which are of general utility and not of direct medical or remedial benefit to the beneficiary including, but not limited to:

F.4.a. – G. ...

1. Such adaptations to the vehicle may include a lift, or other adaptations, to make the vehicle accessible to the beneficiary or for the beneficiary to drive.

2. ...

H. Service Exclusions for Vehicle Adaptations

1. Payment will not be made to:

a. adapt vehicles that are owned or leased by paid caregivers or providers of waiver services; or

b. purchase or lease a vehicle.

2. – 5. ...

I. Provider Responsibilities

1. ...

2. A written itemized, detailed bid, including drawings with the dimensions of the existing and proposed floor plans relating to the modifications, must be obtained and submitted for prior authorization.

I.3. - J. ...

1. Home Adaptations. Providers of environmental accessibility adaptations for the home must:

a. – a.iii. ...

b. be a current Louisiana Medicaid provider of durable medical equipment and have documentation from the manufacturing company (on the manufacturing company’s letterhead) that confirms that the provider is an authorized distributor of a specific product that attaches to a building. The letter must specify the product and state that in which the provider has been trained on its installation.

2. – 3.

4. All environmental adaptation providers, as well as the person performing the service (i.e., building

contractors, plumbers, electricians, engineers, etc.), must meet any state or local requirements for licensure or certification. When state and local building or housing code standards are applicable, modifications to the home shall meet such standards, and all services shall be provided in accordance with applicable state or local requirements.

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 33:2446 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2159 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1513 (October 2021), LR 48:1563 (June 2022), LR 50:

§16313. Host Home

A. – E.2. ...

3. A host home family can provide compensated supports for up to two beneficiaries, regardless of the funding source.

F. – I.7. ...

J. Provider Qualifications

1. – 1.d.

2. Agencies serving children must be licensed by the Department of Children and Family Services as a Class “A” Child Placing Agency under the Specialized Provider Licensing Act 286 of 1985, LAC 48:I.Chapter 41.

3. ...

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

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§16319. One Time Transitional Services

A. ...

B. One-time transitional services may be accessed for the following:

1. – 2. ...

3. essential furnishings to establish basic living arrangements, including:

a. – c. ...

d. window blinds;

B.3.e. – D.3. ...

E. The Office for Citizens with Developmental Disabilities shall be the entity responsible for coordinating the delivery of one-time transitional services. Providers must have a BHSF (Medicaid) provider enrollment agreement as a transition support provider as verified by the Louisiana Department of Health (LDH) Health Standards Section (HSS).

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 33:2449 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2162 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1766 (December 2019), LR 47:1516 (October 2021), LR 48:1565 (June 2022), LR 50:

§16321. Personal Emergency Response System (PERS)

A. – B.2. ...

C. Coverage of the PERS is limited to the rental of the electronic device. PERS services shall include the cost of maintenance and training the beneficiary to use the equipment.

1. Reimbursement will be made for an installation fee for the PERS unit.

2. Monthly Monitoring Fee

a. Enhance Services. Mobile emergency response system (MERS) is an on-the go mobile medical alert system, used in and outside the home. This system will have cellular/GPS technology, two-way speakers and no base station will be required.

D. Service Exclusions

1. – 2. ...

3. Cell phone service is not included and is not a covered waiver service.

a. In addition to the current system that plugs into a landline, a system that uses cellular service may be used and the landline is not required. This system will have a fall detection pendant.

E. – E.4. ...

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§16323. Prevocational Services

A. Prevocational services are individualized, person-centered services that assist beneficiaries in establishing their path to obtain individualized community employment. This service is time limited and targeted for people who have an interest in becoming employed in individual jobs in the community but who may need additional skills, information, and experiences to determine their employment goal and to become successfully employed. Beneficiaries receiving prevocational services may choose to leave this service at any time or pursue employment opportunities at any time.

B. Prevocational services are the overarching services and may be delivered in a combination of these two service types:

1. onsite prevocational services also referred to as onsite community career planning (CP); and

2. CP in a small group

a. prevocational services may be delivered virtually.

3. Repealed.

C. – D. ...

E. The prevocational provider is responsible for all transportation between prevocational sites. Transportation may be provided between the beneficiary's residence, or other location, as agreed upon by the beneficiary or authorized representative, and the prevocational site. The beneficiary's transportation needs shall be documented in the plan of care.

F. Service Limitations

1. Service limits shall be based on the person-centered plan and the beneficiary's ROW budget. Services are delivered in a 15-minute unit of service for up to eight hours per day, one or more days per week. The 15-minute unit of service must be spent at the service site by the beneficiary.

1.a. – 2. ...

3. Prevocational services cannot be billed for at the same time on the same day as the following ROW services, except for community life engagement development or MIHC:

a. – d. ...

e. day habilitation services; or

f. supported employment.

g. Repealed.

4. ...

5. Transportation may be provided on the day that a prevocational service is provided. Transportation is not allowable for virtual delivery of prevocational services.

a. – c. ...

d. Transportation is billed as a separate service that is billed at a daily rate.

G. Restrictions

1. Beneficiaries receiving prevocational services may also receive day habilitation and/or individualized supported employment services, but these services cannot be provided during the same time period.

2. Repealed.

H. Provider Qualifications. Providers must be licensed by the Department of Health as a home and community-based services provider and meet the module requirements for adult day care or supported employment in LAC 48:I.Chapter 50.

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 33:2450 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2162 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1766 (December 2019), LR 47:1516 (October 2021), LR 48:1565 (June 2022) LR 50:

§16325. Professional Services

A. – B.6. ...

C. Professional services can include:

1. – 2. ...

3. intervening in a crisis situation with the goal of stabilizing and addressing issues related to the cause(s) of the crisis. Activities may include development of support plan(s), training, documentation strategies, counseling, on-call supports, back-up crisis supports, on-going monitoring, and intervention;

4. – 8. ...

9. assistance in increasing independence, participation, and productivity in the beneficiary’s home, work, and/or community environments.

***

D. – E. ...

1. Enrollment of individual practitioners. Individual practitioners who enroll as providers of professional services must:

a. – b. ...

c. in addition, the specific service delivered must be consistent with the scope of the license held by the professional.

2. – 4.b. ...

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

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§16327. Respite Care Services–Out of Home

A. ...

1. A licensed respite care facility shall ensure that community activities are available to the beneficiary in

accordance with his approved POC, including transportation to and from these activities.

A.2. – B.3.

C. Service Exclusions

1. ...

2. Respite care services-out of home is not a billable waiver service to a beneficiary receiving the following services:

a. community living supports (may not be provided at the same time on the same day);

b. ...

c. host home; or

d. shared living.

e. Repealed.

C.3. – 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, Office for Citizens with Developmental Disabilities, LR 33:2451 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2164 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and

the Office for Citizens with Developmental Disabilities, LR 45:1767 (December 2019), LR 47:1519 (October 2021), LR 48:1566 (June 2022), LR 50:

§16329. Shared Living Services

A. – A.5. ...

a. Each beneficiary's essential personal rights of privacy, dignity and respect, and freedom from coercion are protected.

6. ...

a. Each beneficiary has the ability to determine whether or with whom he or she shares a room.

b. Each beneficiary has the freedom of choice regarding daily living experiences, which include meals, visitors, and activities.

c. Each beneficiary is not limited in opportunities to pursue community activities.

7. - 8 ...

a. If the person has a legal guardian, the legal guardian's approval must also be obtained.

b. Each beneficiary's plan of care must reflect the shared living services and include the shared rate for the service indicated.

A.9. – B.1. ...

2. ICF/IID residents who choose to transition to a shared living waiver home must also agree to conversion of their residence.

3. – 8. ...

9. In a provider-owned or controlled residential setting, the following additional conditions must be met and any modifications of the conditions must be supported by a specific assessed need and documented in the plan of care.

a. – e. ...

C. Shared Living Options

1. – 4. ...

5. ICF/IID providers who elect to convert to a shared living home via the shared living conversion process shall submit a licensing application for an HCBS provider license, shared living module.

D. Service Exclusions and Limitations

1. – 6.g. ...

7. Shared living services are not available to beneficiaries who are 17 years of age and under.

D.8. – 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, Office for Citizens with Developmental

Disabilities, LR 33:2452 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2164 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1767 (December 2019), LR 47:1519 (October 2021), LR 48:1567 (June 2022), LR 50:

§16333. Support Coordination

A. – A.2. ...

3. Support coordination services include on-going support and assistance to the beneficiary.

B. When beneficiaries choose to self-direct their waiver services, the support coordinator shall provide information, assistance, and management of the service being self-directed.

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, Office for Citizens with Developmental Disabilities, LR 33:2453 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2165 (October 2015), by the Department of

Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, amended LR 47:1521 (October 2021), LR 48:1568 (June 2022), LR 50:

§16335. Supported Employment

A. – D. ...

1. Transportation is payable only when a supported employment service is provided on the same day or when the provider is transporting to/from the job in follow along services.

D.2. – G. ...

1. Individual supported employment services shall be billed in quarter hour (15 minute) units. One-on-one services shall be billed in quarter hour units and shall be based on the person-centered plan and the beneficiary’s ROW budget.

2. Services that assist a beneficiary to develop and operate a micro-enterprise shall be billed in quarter hour (15 minute) units. One-on-one services shall be billed in quarter hour units and shall be based on the person-centered plan and the beneficiary’s ROW budget.

3. Group employment services shall be billed in quarter hour (15 minute) units of service up to eight hours per day and shall be based on the person-centered plan and the beneficiary’s ROW budget.

G.4. – H. ...

1. Payment will only be made for the adaptations, supervision, and training required by individuals receiving waiver services, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

2. Supported employment cannot be billed for at the same time as any other ROW services, except community life engagement development and MIHC.

3. Any time less than the minimum quarter hour (15 minute) unit of service provided for any model is not billable or payable. No rounding up of service units is allowed.

4. Time spent in transportation to and from the program shall not be included in the total number of service hours provided per day.

a. Travel training for the purpose of teaching the beneficiary how to use transportation services may be included in determining the total number of service hours provided per day, but only for the period of time specified in the POC.

b. Transportation is payable only when a supported employment service is provided on the same day and during follow along when the provider is providing the transportation to/from the job.

H.5. – I. ...

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 33:2453 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2166 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1767 (December 2019), LR 47:1521 (October 2021), LR 48:1569 (June 2022), LR 50:

§16337. Transportation-Community Access

A. Transportation-community access services are provided to assist the beneficiary in becoming involved in his or her community. The service encourages and fosters the development of meaningful relationships in the community, which reflects the beneficiary’s choice and values. This service provides the beneficiary with a means of access to community activities and resources. The goal is to increase the beneficiary’s independence, productivity, and community inclusion and to support self-directed employee benefits as outlined in the beneficiary’s POC.

A.1. – C.4. ...

D. Provider Qualifications. Friends and family members who furnish transportation/community access services to waiver beneficiaries, must be enrolled as a Medicaid non-emergency medical transportation (NEMT) family and friends provider with the Louisiana Department of Health, Bureau of Health Services Financing.

1. In order to receive reimbursement for transporting Medicaid beneficiaries to waiver services, family and friends must maintain compliance with the following:

1.a. – 2. ...

3. Documentation of compliance with the three listed requirements for this class of provider must be submitted when enrollment with the Medicaid agency is sought. Acceptable documentation shall be the signed statement of the individual enrolling for payment that all three requirements are met.

D.3.a. – 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, Office for Citizens with Developmental Disabilities, LR 33:2454 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2166 (October 2015), amended by the

Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1768 (December 2019), LR 47:1523 (October 2021), LR 48:1570 (June 2022), LR 50:

§16343. Adult Day Health Care Services

A. – D. ...

E. ADHC services shall be provided no more than 10 hours per day and no more than 50 hours per week.

F. Provider Qualifications:

1. ADHC providers must be licensed according to the adult day health care provider licensing requirements contained in the Revised Statutes (R.S. 40:2120.41-40:2120.47).

2. ADHC providers must be enrolled as a Medicaid ADHC provider.

3. ADHC providers must comply with LDH rules and regulations.

4. Qualifications for ADHC center staff are set forth in the *Louisiana Administrative Code*.

G. – G.4. 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 Services Financing and the Office for Citizens with Developmental Disabilities, 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 45:1768 (December 2019), LR 47:1524 (October 2021), LR 48:1571 (June 2022), LR 50:

§16345. Monitored In-Home Caregiving Services

A. – A.1. ...

2. This goal is achieved by promoting a cooperative relationship between a beneficiary, a principal caregiver, the professional staff of a monitored in-home caregiving agency provider, and the beneficiary’s support coordinator.

B. The principal caregiver is responsible for supporting the beneficiary to maximize the highest level of independence possible by providing necessary care and supports that may include:

1. – 4. ...

5. supervision or assistance while escorting or accompanying the beneficiary outside of the home to perform tasks, including instrumental activities of daily living, health maintenance or other needs as identified in the plan of care and to provide the same supervision or assistance as would be rendered in the home; and

6. ...

C. Service Exclusions and Restrictions

1. Beneficiaries electing monitored in-home caregiving, are not eligible to receive the following ROW services during the period of time that the beneficiaries are receiving monitored in-home caregiving services:

a. – b. ...

c. host home; and

d. shared living supports.

e. Repealed.

D. Monitored in-home caregiving providers must be agency providers who employ professional nursing staff, including a registered nurse and a care manager, and other professionals to train and support principal caregivers to perform the direct care activities in the home.

D.1. – F. ...

G. Provider Qualifications

1. MIHC providers must be licensed according to the HCBS provider licensing requirements contained in the R.S. 40:2120.2-2121.9.

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, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1768 (December

2019), amended LR 47:1525 (October 2021), LR 48:1571 (June 2022), LR 50:

§16347. Community Life Engagement Development

A. Community life engagement development (CLED) should be used for the development of opportunities to assist beneficiaries in becoming involved in their community and to help develop a meaningful day for each beneficiary.

B. The purpose is to encourage and foster the development of meaningful relationships and memberships in the community, reflecting the beneficiary's choices and values.

1. This service will be person-centered with an outcome of increased community activities and involvement in areas of interest as expressed by the beneficiary.

2. This should include church involvement, civic involvement, volunteering opportunities, as well as recreational activities.

3. The activities should be integrated with the community and not segregated groups.

C. The role of CLED should be to develop individual activities, memberships and volunteer positions within the beneficiary's community, based off of each beneficiary's community, based on each beneficiary's person-centered plan and expressed interests and desires.

D. Transportation cost is included in the rate paid to the provider.

E. To use this service, the beneficiary may, or may not, be present.

F. Service limitations:

1. this service can be billed at the same time the beneficiary is receiving a day or employment service;

2. 15-minute unit increments;

3. 240 units per POC year (60 hours) which includes the combination of shared and non-shared CLE;

4. services shall not exceed the number of units as defined in the beneficiary's POC and must have a prior authorization.

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, LAC 50:

§16349. Financial Management Services

A. Financial Management Services (FMS) assist the beneficiary to live independently in the community while controlling his or her services by choosing the staff who work with them.

B. FMS are provided to beneficiaries who have chosen and are capable of self-directing their ROW services.

C. FMS are provided by a Medicaid enrolled Fiscal Employer Agent (F/EA) and the F/EA's responsibilities and standards for participation are identified in LAC 50:XXI.Chapter 11, Subchapters A-C.

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, LAC 50:

Chapter 165. Self-Direction Initiative

§16501. Self-Direction Service Option

A. ...

1. Beneficiaries are informed of all available services and service delivery options, including self-direction, at the time of the initial assessment, annually, or as requested by beneficiaries or their authorized representative. Beneficiaries who are interested in self-direction need only notify their support coordinator who will facilitate the enrollment process.

2. A fiscal/employer agent is responsible for processing the beneficiary's employer-related payroll, withholding and depositing the required employment-related

taxes, and sending payroll reports to the beneficiary or his/her authorized representative.

3. Support coordinators assist beneficiaries by providing the following activities:

a. – d. ...

e. back-up service and emergency preparedness planning;

A.3.f. – B.3. ...

* * *

C. Beneficiary Responsibilities. Responsibilities of the waiver beneficiary or his or her authorized representative include the following:

1. – 1.b. ...

2. Waiver beneficiary’s participation in the development and management of the approved personal purchasing plan.

a. This annual budget is determined by the recommended service hours listed in the beneficiary’s POC to meet his or her needs.

b. – 3. ...

4. Prior to enrolling in self-direction, the beneficiary or his or her authorized representative is trained by the support coordinator on the process for completing the following duties:

a. – k. ...

l. back-up service planning.

5. – 7. ...

D. Termination of Self-Direction Service Option. Termination from this option may be either voluntary or involuntary and the support coordinator will assist with the transition. Termination of participation in the self-direction service option requires a revision of the POC, the elimination of the fiscal agent and the selection of the Medicaid-enrolled waiver service provider(s) of choice.

1. ...

a. Proper arrangements will be made by the support coordinator to ensure that there is no lapse in services.

b. Should the request for voluntary withdrawal occur, the beneficiary will receive counseling and assistance from his or her support coordinator immediately upon identification of issues or concerns in any of the above situations.

c. Beneficiaries may choose, at any time, to voluntarily return to a traditional direct service provider (DSP). Beneficiaries who return to a traditional DSP must remain with this DSP for at least 90 calendar days (three months)

before opting to return to the self-direction option, if they are eligible to do so.

2. Involuntary Termination. The department may terminate the self-direction service option for a beneficiary and require him or her to receive provider-managed services under the following circumstances:

a. – b. ...

c. the beneficiary is no longer able to direct his or her own care and there is no responsible representative to direct the care;

d. ...

e. over three payment cycles in the period of a year, the beneficiary or authorized representative:

i. permits employees to work over the hours approved in the beneficiary's plan of care or allowed by the beneficiary's program;

e.ii – f. ...

g. a beneficiary may be removed from Self-Direction and required to return to traditional DSP if there are any violations of the ROW or Self-Direction program rules.

3. When action is taken to terminate a beneficiary from self-direction involuntarily, the support coordinator immediately assists the beneficiary in accessing needed and appropriate services through the ROW and other available

programs, ensuring that no lapse in necessary services occurs for which the beneficiary is eligible. There is no denial of services, only the transition to a different payment option. The beneficiary and support coordinator are provided with a written notice explaining the reason for the action and citing the policy reference.

E. Employees of beneficiaries in the self-direction service option are not employees of the fiscal agent or the department.

1. Employee Qualifications. All employees under the self-direction option must meet the qualifications for furnishing personal care services as set forth in LAC 48:I.Chapter 92.

F. ...

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 33:2455 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2167 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR

47:1525 (October 2021), LR 48:1572 (June 2022), LR 49:1727 (October 2023), LR 50:

Chapter 167. Provider Participation

§16701. General Provisions

A. – C. ...

1. Exception. The following services may be provided when the beneficiary is not present:

a. ...

b. personal emergency response systems;

c. one-time transitional services; and

d. community life engagement development.

2. All services must be documented in service notes which describe the services rendered and progress towards the beneficiary’s personal outcomes and his or her POC.

D. – E. ...

F. Some ROW services may be provided by a member of the beneficiary’s family, provided that the family member meets all requirements of a non-family direct support worker and provision of care by a family member is in the best interest of the beneficiary.

1. Payment for services rendered are approved by prior and post authorization as outlined in the POC.

2. Payments to legally responsible individuals, legal guardians, and family members living in the home shall be

audited on a semi-annual basis to ensure payment for services rendered.

G. – G.3.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 for Citizens with Developmental Disabilities, LR 33:2455 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2168 (October 2015), LR 42:63 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1527 (October 2021), LR 48:1573 (June 2022), LR 50:

§16703. Staffing Restrictions and Requirements

A. ...

B. In order to receive payment, relatives must meet the criteria for the provision of the service and the same provider qualifications specified for the service as other providers not related to the beneficiary.

1. – 1.c.ii. ...

2. Family members who may provide services include:

a. parents/guardians of minor children and adult children;

b. – c. ...

d. aunts and uncles;

e. cousins; and

f. in-laws.

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 41:2168 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1527 (October 2021), LR 48:1573 (June 2022), LR 50:

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 beneficiary. 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. – 4.b. ...

5. professional services furnished by a/an:

a. – d. ...

e. social worker; or

5.f. – 9. ...

EXCEPTION: Repealed.

B. The following services shall be reimbursed at the authorized rate or approved amount of the assessment, installation/fitting, maintenance, repairs, adaptation, device, equipment, or supply item and when the service has been prior authorized by the POC:

1. environmental accessibility adaptations:

a. upon completion of the environmental accessibility adaptations and prior to submission of a claim for reimbursement, the provider shall give the beneficiary a certificate of warranty for all labor and installation work and supply the beneficiary with all manufacturers' warranty certificates;

2. assistive technology/specialized medical equipment and supplies;

3. personal emergency response system (PERS) installation; and

4. monitored in-home caregiving (MIHC) assessment.

C. – C.4.a. ...

D. The following services shall be reimbursed at an established monthly rate:

1. support coordination:

a. the reimbursement for support coordination shall be in accordance with the terms of the established contract;

2. monthly service fee for PERS; and

3. financial management services.

EXCEPTION: The reimbursement for support coordination shall be at a fixed monthly rate and in accordance with the terms of the established contract.

E. The reimbursement for transportation services is a flat fee based on a capitated rate.

F. Nursing services are reimbursed at either an hourly or per visit rate for the allowable procedure codes.

G. Transition expenses from an ICF/IID or nursing facility to a community living setting are reimbursed at the cost of the service(s) up to a lifetime maximum rate of $3,000.

H. Dental Services. Dental services are reimbursed according to the LA Dental Benefit Program.

I. Reimbursement Exclusion. No payment will be made for room and board under this waiver program.

J. 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 33:2456 (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 43:2530 (December 2017), LR 45:1769 (December 2019), LR 47:1527 (October 2021), LR 48:1573 (June 2022), LR 50:

§16903. Direct Service Worker Wages and Bonus Payments

A. Establishment of Direct Service Worker Wage Floor for Medicaid Home and Community-Based Services for Intellectual and Developmental Disabilities

1. ...

2. Effective October 1, 2021, this increase or its equivalent will be applied to all service units provided by direct service workers with an effective date of service for the identified home and community-based waiver services provided beginning October 1, 2021.

A.3. – C.5.b. ...

D. Sanctions for Direct Service Worker Wage Floor and Workforce Bonus Payments

1. The provider will be subject to sanctions or penalties for failure to comply with this Rule or with requests

issued by LDH pursuant to this Rule. The severity of such action will depend upon the following factors:

a. Direct Service Worker Wage Floor;

i. – iii. ...

b. Direct Service Worker Workforce Bonus Payments;

b.i. – c. ...

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 41:2169 (October 2015), 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 48:42R (January 2022), LR 49:1071 (June 2023), LR 50:

Michael Harrington, MBA, MA

Secretary

RULE

Department of Health
Bureau of Health Services Financing
and
Office of Aging and Adult Services

Home and Community-Based Services Waivers
Support Coordination Standards for Participation
(LAC 50:XXI.Chapter 5)

The Department of Health, Bureau of Health Services Financing and Office of Aging and Adult Services has amended LAC 50:XXI.Chapter 5 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. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community-Based Services Waivers
Subpart 1. General Provisions

Chapter 5. Support Coordination Standards for Participation for Office of Aging and Adult Services Waiver Programs

Subchapter A. General Provisions

§501. Introduction

A. The Louisiana Department of Health (LDH) establishes these minimum standards for participation which provides the core requirements for support coordination services provided under home and community-based services waiver programs

administered by the Office of Aging and Adult Services (OAAS). OAAS must determine the adequacy of quality and protection of waiver participants in accordance with the provisions of these standards.

B. – D.1. ...

E. If a support coordination agency fails to comply and /or is unable to comply with their requirements as a certified support coordination agency, OAAS may temporarily perform the mandatory duties of the support coordination agency to ensure the continuity of the participants' services and the participants' health and welfare. The support coordination agency shall not be reimbursed for support coordination duties performed by OAAS.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3086 (November 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 47:886 (July 2021), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§503. Certification Requirements

A. All agencies that provide support coordination to OAAS administered home and community-based services (HCBS) waivers must be certified by LDH. It shall be unlawful to operate as a support coordination agency for OAAS administered HCBS waiver programs without being certified by the department.

B. In order to provide support coordination services for OAAS administered HCBS waiver programs, the agency must:

1. – 3. ...

4. enroll as a Medicaid support coordination agency in all regions in which it intends to provide services for OAAS administered HCBS waiver programs; and

5. comply with all LDH and OAAS policies and procedures.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3087 (November 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§505. Certification Issuance

A. A certification shall:

1. – 2. ...

3. enable the support coordination agency to provide support coordination for OAAS administered HCBS waivers within the specified LDH region; and

4. ...

B. Provisional certification may be granted when the agency has deficiencies which are not a danger to the health and welfare of participants. Provisional certification shall be issued for a period not to exceed 90 calendar days.

C. Initial certification shall be issued by OAAS based on the survey report of LDH, or its designee.

D. Unless granted a waiver by OAAS, a support coordination agency shall provide such services only to waiver participants residing in the agency's designated LDH region(s).

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3087 (November 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

Subchapter B. Administration and Organization

§515. Business Location and Operations

A. Each support coordination agency shall have a business location which shall not be in an occupied personal residence.

The business location shall be in the LDH region for which the certification is issued and shall be where the agency:

A.1. – B.6. ...

C. Records and other confidential information shall be secure and protected from unauthorized access.

D. Each support coordination agency must utilize business issued email accounts that are private, secure, and HIPAA compliant, and must not use publicly available email addresses.

E. All email that involves PHI must be sent utilizing a secure email process.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3088 (November 2013), amended LR 40:1936 (October 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§519. Policy and Procedures

A. The support coordination agency shall have written policies and procedures approved by the owner or governing body which must be implemented and followed that address at a minimum the following:

1. – 4. ...

5. statewide criminal history background checks;

6. database checks upon hire and monthly thereafter;

7. participant rights;

8. grievance procedures;

9. emergency preparedness;

10. abuse and neglect reporting;

11. critical incident reporting;

12. worker safety;

13. documentation; and

14. admission and discharge procedures.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3088 (November 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§521. Organizational Communication

A. – C. ...

D. The support coordination agency shall be responsible for:

1. obtaining written approval of the brochure from OAAS prior to distributing to applicants/participants of OAAS-administered HCBS waiver programs;

2. – 3. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3089 (November 2013), amended LR 40:1936 (October 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

Subchapter C. Provider Responsibilities

§525. General Provisions

A. Any entity wishing to provide support coordination services for any OAAS administered HCBS waiver program shall meet all of the standards for participation contained in this Rule, unless otherwise specifically noted within these provisions.

B. The support coordination agency shall also abide by and adhere to any federal, state law, Rule, policy, procedure, performance agreement, manual or memorandum pertaining to the provision of support coordination services for OAAS administered HCBS waiver programs.

C. Failure to comply with the requirements of these standards for participation may result in sanctions including, but not limited to:

1. monetary sanctions;

2. suspension of payments;

3. recoupments;

4. cessation of linkages

5. citation of deficient practice and plan of correction submission;

6. removal from the freedom of choice list;

7. decertification as a support coordination agency for OAAS administered HCBS waiver services; and/or

8. termination of support coordination performance agreement.

D. ...

E. Designated representatives of the department, in the performance of their mandated duties, shall be allowed by a support coordination agency to:

1. inspect all aspects of a support coordination agency’s operations which directly or indirectly impact participants; and

E.2. – G. ...

H. Support coordination agencies shall, at a minimum:

1. maintain and/or have access to a comprehensive resource directory containing all of the current inventory of existing formal and informal resources that identifies services

within the geographic area which shall address the unique needs of participants of OAAS administered HCBS waiver programs;

2. ...

3. demonstrate knowledge of the eligibility requirements and application procedures for federal, state and local government assistance programs, which are applicable to participants of OAAS administered HCBS waiver programs;

4. – 5. ...

6. ensure that all agency staff are employed in accordance with Internal Revenue Service (IRS) and Department of Labor regulations (subcontracting of individual support coordinators and/or supervisors is prohibited);

7. have appropriate agency staff attend trainings, as mandated by LDH and OAAS;

8. – 9. ...

10. ensure each participant has freedom of choice in the selection of available qualified providers and the right to change providers in accordance with program guidelines; and

11. ensure that the agency and support coordinators will not provide both support coordination and Medicaid-reimbursed direct services to the same participant(s).

I. Abuse and Neglect. Support coordination agencies shall establish policies and procedures relative to the reporting of abuse and neglect of participants, 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.

J. Ensure that statewide criminal history background checks are performed on all unlicensed persons working for the support coordination agency (SCA) in accordance with R.S. 40:1203.1 et seq. and/or other applicable state law upon hire;

1. ensure that the SCA 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 SCA shall maintain documentation on the final disposition of all charges that bars employment pursuant to applicable state law.

K. Ensure that all employees, including contractors, are not excluded from participation in the Medicaid programs by checking the databases upon hire and then monthly thereafter.

1. the SCA shall maintain documentation of the results of these database checks.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3089 (November 2013),

amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§527. Support Coordination Services

A. Support coordination is a mandatory service in the OAAS waiver programs that assists participants in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, housing and other services, regardless of the funding source for these services. Support coordination agencies shall be required to perform the following core elements of support coordination services:

1. intake;

2. assessment and re-assessment;

3. plan of care development and revision;

4. follow-up/monitoring;

5. critical incident management; and

6. transition discharge and closure.

7. – 9. Repealed

B. The support coordination agency shall also be responsible for completing the following functions:

1. linkage to direct services and other resources;

2. assessing, addressing and documenting delivery of services, including remediation of difficulties encountered by participants in receiving direct services;

3. coordination of multiple services among multiple providers;

4. ongoing assessment and mitigation of health, behavioral and personal safety risk; and

5. responding to participant crisis.

C. A support coordination agency shall not refuse to serve, or refuse to continue to serve, any individual who chooses/has chosen its agency unless there is documentation to support an inability to meet the individual's health and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services.

C.1. – D. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3090 (November 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§529. Transfers and Discharges

A. All participants of OAAS administered waiver programs must receive support coordination services. However, a participant has the right to choose a support coordination agency. This right includes the right to be discharged from

his/her current support coordination agency and/or be transferred to another support coordination agency.

B. ...

C. The support coordination agency shall also have the responsibility of planning for a participant's transfer when the support coordination agency ceases to operate or when the participant moves from the geographical region serviced by the support coordination agency.

1. If a support coordination agency ceases to operate, the agency must give OAAS at least 60 calendar days written notice of its intent to close. Where transfer of participants is necessary due to the support coordination agency closing, the written discharge summary for all participants served by the agency shall be completed within 10 working days of the notice to OAAS of the agency's intent to close.

D. – D.3 ...

E. The written discharge summary, along with the current plan of care, shall be completed and provided to the receiving support coordination (if applicable) agency and OAAS regional office, within five working days of any of the following:

1. – 2. ...

3. notice by the participant or authorized representative that the participant will be transferring to a

LDH geographic region not serviced by his/her current support coordination agency; or

E.4. – F. ...

G. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3090 (November 2013), amended LR 40:1936 (October 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§531. Staffing Requirements

A. Agencies must maintain sufficient staff to comply with OAAS staffing, timelines, workload, and performance requirements. This includes, but is not limited to, including sufficient support coordinators and support coordination supervisors that have passed all of the OAAS training and certification requirements. At all times, an agency must have at least one certified support coordination supervisor and at least one certified support coordinator, both employed full time. Agencies may employ staff who are not certified to perform services or requirements other than assessment and care planning.

B. – B.2. ...

C. Agencies shall employ or contract a licensed registered nurse to serve as a consultant. The nurse consultant shall work a minimum of 16 hours per month.

D. ...

E. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3091 (November 2013), amended LR 40:1937 (October 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§533. Personnel Standards

A. Support coordinators must meet one of the following requirements:

1. a bachelor’s or master’s degree in social work from a program accredited by the Council on Social Work Education; or

2. a diploma, associate’s, bachelor’s or master’s degree in nursing (RN) currently licensed in Louisiana; or

3. a bachelor’s or master’s degree in a human service related field which includes:

a. – i. ...

j. substance abuse;

k. gerontology; or

l. vocational rehabilitation; or

4. a bachelor’s degree in liberal arts or general studies with a concentration of at least 16 hours in one of the fields in §533.A.3.a-l of this Section; or

5. a bachelor’s or master’s degree in a field other than those listed in §533.A.1.- 4, if approved by OAAS.

B. Support coordination supervisors must meet the following requirements:

1. a bachelor’s or master’s degree in social work from a program accredited by the Council on Social Work Education; or

2. a bachelor’s or master’s degree in nursing (RN), currently licensed in Louisiana; or

3. a bachelor’s or master’s degree in a human service related field which includes: psychology, education, counseling, social services, sociology, philosophy, family and participant sciences, criminal justice, rehabilitation services, child development, substance abuse, gerontology, and vocational rehabilitation; or

4. a bachelor’s degree in liberal arts or general studies with a concentration of at least 16 hours in one of the

following fields: psychology, education, counseling, social services, sociology, philosophy, family and participant sciences, criminal justice, rehab services, child development, substance abuse, gerontology, or vocational rehabilitation; or

5. a bachelor's or master's degree in a field other than those listed in §533.B.1.- 4, if approved by OAAS; and

6. have two years of paid post degree experience in providing support coordination services.

C. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3091 (November 2013), amended LR 40:1937 (October 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§537. Orientation and Training

A. – B. ...

C. Orientation and training of at least 32 hours shall be provided by the agency to all newly hired support coordinators and support coordination supervisors within five working days of employment. The topics shall be agency/OAAS specific and shall include, at a minimum:

1. – 16. ...

D. Upon completion of the agency-provided training requirements set forth above, newly hired support coordinators and support coordination supervisors must successfully complete all OAAS assessment and care planning training (if applicable).

E. ...

F. All support coordinators and support coordination supervisors must complete a minimum of 16 hours of training per year. The 32 hours of orientation and initial training for support coordinators and support coordination supervisors required in the first 90 calendar days of employment may be counted toward the 16 hour minimum annual training requirement. Routine supervision shall not be considered training.

G. – H. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3092 (November 2013), amended LR 40:1937 (October 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§543. Critical Incident Reporting

A. Support coordination agencies shall report critical incidents according to established OAAS policy including timely entries into the designated LDH critical incident database.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3093 (November 2013), amended LR 40:1938 (October 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§545. Participant Records

A. Participant records shall be maintained in the support coordinator’s office. The support coordinator shall have a current record for each participant.

B. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3093 (November 2013), amended LR 40:1938 (October 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§547. Emergency Preparedness

A. Support coordination agencies shall ensure that each participant has an individual plan for dealing with emergencies and disasters and shall assist participants in identifying the specific resources available through family, friends, the neighborhood, and the community. The support coordination agency shall assess monthly whether the emergency plan information is current and effective and shall make changes accordingly.

B. – C. ...

D. The support coordination agency shall cooperate with the department and with the local or parish Office of Homeland Security and Emergency Preparedness in the event of an emergency or disaster and shall provide information as requested.

E. The support coordination agency shall monitor weather warnings and watches as well as evacuation orders from local and state emergency preparedness officials.

F. – G. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3094 (November 2013), amended LR 40:1938 (October 2014), amended by the Department of

Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§551. Support Coordination Agency Monitoring

A. Support coordination agencies shall be monitored as outlined in the OAAS policies and procedures and the support coordination performance agreement.

B. – B.3. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3095 (November 2013), amended LR 40:1939 (October 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§553. Workforce Retention Bonus Payments

A. – A.2. ...

B. Audit Procedures for Support Coordination Workforce Bonus Payments

B.1. – 5.b. ...

C. Sanctions for Support Coordination Workforce Bonus Payments

C.1.d. ...

§555. Cost Reporting Requirements

A. Support coordination agencies (SCAs) must submit annual cost reports with a fiscal year from July 1st through June 30th to the department to verify expenditures and to support rate setting for the services rendered to waiver participants.

B. Each SCA must complete the LDH approved cost report and submit the cost report(s) to the department no later than November 30th, which is five months after the state’s fiscal year end date (June 30th).

C. When the SCA fails to submit the cost report by November 30th, which is five months after the state’s fiscal year end date (June 30th), a penalty of 5 percent of the total monthly payment for the first month and a progressive penalty of 5 percent of the total monthly payment for each succeeding month may be levied and withheld from the SCA’s payment for each month that the cost report is due, not extended and not received. If no claims are submitted for payment during the time of the penalty implementation, the penalty will be imposed when the provider commences submitting claims for payment. The late filing penalty is non-refundable and not subject to an administrative appeal.

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 of Aging and Adult Services, LR 49:685 (April 2023), amended LR 50:

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.

Michael Harrington, MBA, MA

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
(LAC 50:XXI.Chapters 57 and 59)

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities has amended LAC 50:XXI.Chapters 57 and 59 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. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XXI. Home and Community-Based Services Waivers
Subpart 5. Supports Waiver

Chapter 57. Covered Services

§5701. Supported Employment Services

A. – C. ...

D. Transportation is a separate billable component for supported employment services, both individual and group. Transportation may be billed on the same day as a supported employment service is delivered or if follow-along supports are on the plan of care (POC).

E. – 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 43:2532 (December 2017), LR 48: LR 48:1575 (June 2022), LR 50:212 (February 2024), LR 50:

§5725. Specialized Medical Equipment and Supplies

A. Specialized Medical Equipment and Supplies

1. Incontinence briefs and supplies are available for a beneficiary, 21 years or older, who has a physician’s order and requires the use of incontinence briefs and supplies.

2. Assistive technology (AT), which may include remote features, is a service intended to increase the individual’s ability to perform activities more independently in their home, at their job, traveling around their community and/or communicating with others. The service may include equipment and applications that are used to support an

individual remotely and increase their safety, independence and control. This service includes a consultation and, if needed, a monthly subscription fee.

B. Service Restrictions

1. Incontinence supplies are for those who are 21 years of age or older.

2. Assistive technology with remote features is for anyone 18 years or older.

3. Incontinence supplies require a physician’s order.

4. An AT consultation is available if needed.

C. Service Limitations

1. Incontinence supplies’ cost cannot exceed $2,500 in a single plan of care year.

2. Assistive technology with remote features services shall not exceed the number of units of service as outlined in the plan of care, and must have a prior authorization.

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 50:214 (February 2024), LR 50:

Chapter 59. Provider Participation

§5901. General Provisions

A. – B. ...

C. In addition to meeting the requirements cited in §5901.A and B, providers must meet the following requirements for the provision of designated services:

1. Day Habilitation and Prevocational Services. The provider must possess a current, valid license as an adult day care center in order to provide these services and for the community career planning service (prevocational), the provider may possess a valid certificate as a community rehabilitation provider (CRP) from an approved program or the certification and training as required per OCDD.

2. - 7. ...

8. Specialized Medical Equipment and Supplies. Providers of this service must be enrolled to participate in the Medicaid Program as a provider of assistive technology, specialized medical equipment, and supplies.

9. Community Life Engagement Development. Providers of this service must possess a valid adult day care license and provide day habilitation 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, 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 43:2532 (December 2017), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2532 (December 2017), LR 48:1579 (June 2022), LR 50:215 (February 2024), LR 50:

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.

Michael Harrington, MBA, MA

Secretary

RULE

Department of Health
Bureau of Health Services Financing
and
Office of Aging and Adult Services

Long Term Personal Care Services
(LAC 50:XV.Chapter 129)

The Department of Health, Bureau of Health Services Financing and Office of Aging and Adult Services has amended LAC 50:XV.Chapter 129 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. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XV. Services for Special Populations

Chapter 129. Long Term Care

§12907. Recipient Rights and Responsibilities

A. Recipients who receive services under the Long-Term Personal Care Services Program have the right to actively participate in the development of their plan of care and the decision-making process regarding service delivery. Recipients also have the right to freedom of choice in the selection of a provider of personal care services and to participate in the following activities:

1. – 4. ...

5. signing off /approving time entries and other documentation to verify staff work hours and to authorize payment;

A.6. – 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 29:912 (June 2003), amended LR 30:2832 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2579 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2508 (September 2013), LR 42:903 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§12909. Standards for Participation

A. – A.2. ...

B. In addition, a Medicaid enrolled agency must:

1. ...

2. ensure that all agency staff are employed in accordance with Internal Revenue Service (IRS) and U.S. Department of Labor regulations.

3. ensure that statewide criminal history background checks are performed on all unlicensed persons working for the provider in accordance with R.S. 40:1203.1 et. seq. and/or other applicable state law upon hire;

a. 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;

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

4. ensure that all employees, including contractors, have not been excluded from participation in the Medicaid programs by checking the databases upon hire and monthly thereafter.

a. the provider shall maintain documentation of the results of these database checks.

C. – E.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 29:912 (June 2003), amended LR 30:2832 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2579 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2451 (November 2009), LR 39:2508 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services and the Office for Citizens with Developmental Disabilities, LR 43:1980 (October 2017), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§12917. Rate Methodology

A. A rate validation process will occur every two years, at a minimum, to determine the sufficiency of reimbursement rates. The rate validation process will involve the comparison of current provider reimbursement rates to reimbursement rates established using the department’s reimbursement methodology.

1. The department’s reimbursement methodology will establish an estimated reimbursement through the summation of the following two rate component totals:

a. adjusted staff cost rate component; and

b. other operational cost rate component.

2. The adjusted staff cost rate component will be determined in the following manner.

a. Direct service worker wage expense, contract labor expense, and hours worked for reimbursable assistance services will be collected from provider cost reports.

i. Collected wage and contract labor expense will be divided by collected hours worked, on an individual cost report basis, to determine a per hour labor rate for direct service workers.

ii. The individual cost report hourly labor rates will be aggregated for all applicable filed cost reports, outliers will be removed, and a simple average statewide labor rate will be determined.

b. A blended direct service worker labor rate will be calculated by comparing the simple average statewide labor rate to the most recently available, as of the calculation of the department’s rate validation process, average personal care aide wage rate from the Louisiana Occupational Employment and Wages report for all Louisiana parishes published by the Louisiana Workforce Commission (or its successor).

i. If the simple average statewide labor rate is less than the wage rate from the Louisiana Occupational Employment and Wages report, a blended wage rate will be calculated using 50 percent of both wage rates.

ii. If the simple average statewide labor rate is equal to or greater than the wage rate from the Louisiana Occupational Employment and Wages report, the simple average statewide labor rate will be utilized.

c. An employee benefit factor will be added to the blended direct service worker wage rate to determine the unadjusted hourly staff cost.

i. Employee benefit expense allocated to reimbursable assistance services will be collected from provider cost reports.

ii. Employee benefit expense, on an individual cost report basis, will be divided by the cost report direct service wage and contract labor expense for reimbursable assistance services to calculate employee benefits as a percentage of labor costs.

iii. The individual cost report employee benefit percentages will be aggregated for all applicable filed cost reports, outliers will be removed, and a simple average statewide employee benefit percentage will be determined.

iv. The simple average statewide employee benefit percentage will be multiplied by the blended direct service worker labor rate to calculate the employee benefit factor.

d. The department will be solely responsible for determining if adjustments to the unadjusted hourly staff cost for items that are underrepresented or not represented in provider cost reports are considered appropriate.

e. The unadjusted hourly staff cost will be multiplied by a productive hours adjustment to calculate the hourly adjusted staff cost rate component total. The productive hours adjustment allows the reimbursement rate to reflect the cost associated with direct service worker time spent performing required non-billable activities. The productive hours adjustment will be calculated as follows.

i. The department will determine estimates for the amount of time a direct service worker spends performing required non-billable activities during an eight hour period. Examples of non-billable time include, but are not limited to: meetings, substitute staff, training, wait-time, supervising, etc.

ii. The total time associated with direct service worker non-billable activities will be subtracted from eight hours to determine direct service worker total billable time.

iii. Eight hours will be divided by the direct service worker total billable time to calculate the productive hours' adjustment.

3. The other operational cost rate component will be calculated in the following manner.

a. Capital expense, transportation expense, other direct non-labor expense, and other overhead expense allocated to reimbursable assistance services will be collected from provider cost reports.

b. Capital expense, transportation expense, supplies and other direct non-labor expense, and other overhead expense, on an individual cost report basis, will be divided by the cost report direct service wage and contract labor expense for reimbursable assistance services to calculate other operational costs as a percentage of labor costs.

c. The individual cost report other operational cost percentages will be aggregated for all applicable filed cost reports, outliers will be removed, and a simple average statewide other operational cost percentage will be determined.

d. The simple average other operational cost percentage will be multiplied by the blended direct service worker labor rate to calculate the other operational cost rate component.

4. The calculated department reimbursement rates will be adjusted to a one quarter hour unit of service by dividing the hourly adjusted staff cost rate component and the hourly other operational cost rate component totals by four.

5. The department will be solely responsible for determining the sufficiency of the current reimbursement rates during the rate validation process. Any reimbursement rate change deemed necessary due to the rate validation process will be subject to legislative budgetary appropriation restrictions prior to implementation.

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 29:913 (June 2003), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:253 (February 2008), LR 34:2581 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:1901 (September 2009), LR 36:1251 (June 2010), LR 37:3267 (November 2011), LR 39:1780 (July 2013), LR 42:904 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR:47:594 (May 2021), LR 49:697 (April 2023), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§12919. Reimbursement

A. Reimbursement for long term personal care services shall be a prospective flat rate for each approved unit of service that is provided to the participant. One quarter hour (15 minutes) is the standard unit of service for LT-PCS. Reimbursement shall not be paid for the provision of less than one quarter hour (15 minutes) of service. Additional reimbursement shall not be available for transportation furnished during the course of providing LT-PCS.

B. The state has the authority to set and change LT-PCS rates and/or provide lump sum payments to LT-PCS providers based upon funds allocated by the legislature.

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 39:1052 (April 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR:47:594 (May 2021), amended LR 50:

§12921. Cost Reporting Requirements [Formerly §12919]

A. LT-PCS providers must submit annual cost reports with a fiscal year from July 1 through June 30 to the department to verify expenditures and to support rate setting for the services rendered to HCBS LT-PCS participants.

1. – 5. Repealed.

B. Each LT-PCS provider must complete the LDH approved cost report and submit the cost report(s) to the department no later than November 30, five months after the state’s June 30 fiscal year end date.

1. – 2. Repealed.

C. When the LT-PCS provider fails to submit a cost report by November 30th, five months after the state’s June 30 fiscal year end date , a penalty of 5 percent of the total monthly payment for the first month and a progressive penalty of 5 percent of the total monthly payment for each succeeding month may be levied and withheld from the provider’s payment for each month that the cost report is due, not extended and not received. If no claims are submitted for payment during the time of the penalty implementation, the penalty will be imposed when the provider commences submitting claims for payment. The late filing penalty is non-refundable and not subject to an administrative appeal.

C.1. – D.1.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, Bureau of Health Services Financing, LR 39:1052 (April 2013), amended by the Department of Health, Bureau of

Health Services Financing and the Office of Aging and Adult Services, LR:47:594 (May 2021), amended , LR 50:

§12923. Direct Service Worker Wages, Other Benefits, and Workforce Bonus Payments [Formerly §12921]

A. Establishment of Direct Service Worker Wage Floor and Other Benefits

1. Long term-personal care services (LT-PCS) providers that were providing LT-PCS on or after October 1, 2021 and employing direct service workers (DSWs) will receive the equivalent of a $4.50 per hour rate increase.

2. This increase, or its equivalent, will be applied to all service units provided by DSWs with an effective date of service for the LT-PCS provided on or after October 1, 2021.

3. All LT-PCS providers affected by this rate increase shall be subject to passing 70 percent of their rate increases directly to the DSW in various forms. These forms include a minimum wage floor of $9 per hour and wage and non-wage benefits. This wage floor and wage and non-wage benefits are effective for all affected DSWs of any working status, whether full-time or part-time.

4. The Louisiana Department of Health (LDH) reserves the right to adjust the DSW wage floor and/or wage and non-wage benefits as needed through appropriate rulemaking promulgation consistent with the Administrative Procedure Act.

B. Establishment of Direct Service Worker Workforce Bonus Payments

1. LT-PCS providers who provided services from April 1, 2021 to October 31, 2022, shall receive bonus payments of $300 per month for each DSW that worked with participants for those months.

2. The DSW who provided services from April 1, 2021 to October 31, 2022 to participants must receive at least $250 of this $300 bonus payment paid to the provider. This bonus payment is effective for all affected DSWs of any working status, whether full-time or part-time.

C. Audit Procedures for Direct Service Worker Wage Floor, Other Benefits, and Workforce Bonus Payments

1. The wage enhancements, wage and non-wage benefits and bonus payments reimbursed to LT-PCS providers shall be subject to audit by LDH.

2. LT-PCS providers shall provide LDH or its representative all requested documentation to verify that they are in compliance with the DSW wage floor, wage and non-wage benefits and/or bonus payments.

3. This documentation may include, but is not limited to: payroll records, wage and salary sheets, check stubs, etc.

4. LT-PCS providers shall produce the requested documentation upon request and within the timeframe provided by LDH.

5. Non-compliance or failure to demonstrate that the wage enhancement, wage and non-wage benefits and/or bonus payments were paid directly to DSWs may result in the following:

a. sanctions; or

b. disenrollment from the Medicaid program.

D. Sanctions for Direct Service Worker Wage Floor, Other Benefits, and Workforce Bonus Payments

1. The LT-PCS provider will be subject to sanctions or penalties for failure to comply with this Rule or with requests issued by LDH pursuant to this Rule. The severity of such action will depend upon the following factors:

a. failure to pass 70 percent of the LT-PCS provider rate increases directly to the DSWs in the form of a floor minimum of $9 per hour and in other wage and non-wage benefits and/or the $250 monthly bonus payments;

b. the number of employees identified that the LT-PCS provider has not passed 70 percent of the LT-PCS provider rate increases directly to the DSWs in the form of a floor minimum of $9 per hour and in other wage and non-wage benefits and/or the $250 monthly bonus payments;

c. the persistent failure to not pass 70 percent of the LT-PCS provider rate increases directly to the LT-PCS DSWs in the form of a floor minimum of $9 per hour and in other wage and non-wage benefits and/or the $250 monthly bonus payments; or

d. failure to provide LDH with any requested documentation or information related to or for the purpose of verifying compliance with this Rule.

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 29:913 (June 2003), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2581 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2451 (November 2009), LR 39:2509 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

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.

Michael Harrington, MBA, MA

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Pharmacy Benefits Management Program
Pharmacy Copayment
(LAC 50.XXIX.111)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XXIX.111 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. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XXIX. Pharmacy

Chapter 1. General Provisions

§111. Copayment

A. Payment Schedule

1. A copayment requirement in the Pharmacy Program is based on the following payment schedule.

Calculated State Payment	Copayment
$5.00 or less	$0.00
$5.01 to $10.00	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

A.2. – B.5. ...

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, LR 32:1055 (June 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1181 (June 2017), LR 43:1553 (August 2017), LR 46:34 (January 2020), LR 48:2975 (December 2022), LR 50:

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.

Michael Harrington, MBA, MA

Secretary