RULE

Department of Health
Bureau of Health Services Financing

Abortion Facilities
Licensing Standards
(LAC 48:I.4401 and 4431)

The Department of Health, Bureau of Health Services Financing has amended LAC 48:I.4401 and §4431 as authorized by R.S. 36:254 and R.S. 40:2175.1 et seq. 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 48

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

Chapter 44. Abortion Facilities

Subchapter A. General Provisions

§4401. Definitions

Abortion or Induced Abortion—the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:

1. save the life or preserve the health of an unborn child;

2. remove a dead unborn child or induce delivery of the uterine contents in case of a positive diagnosis, certified in writing in the woman's medical record along with the results of an obstetric ultrasound test, that the pregnancy has ended or is in the unavoidable and untreatable process of ending due to spontaneous miscarriage, also known in medical terminology as spontaneous abortion, missed abortion, inevitable abortion, incomplete abortion, or septic abortion; or

3. remove an ectopic pregnancy.

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Certified Registered Nurse Anesthetist (CRNA)—a licensed health care practitioner who is acting within the scope of practice of his/her respective licensing board(s) and/or certifications.

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CRNA—Repealed.

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Genetic Abnormality—any defect, disease, or disorder that is inherited genetically. The term includes, without limitation, any physical disfigurement, scoliosis, dwarfism, Down syndrome, albinism, amelia, and any other type of physical, mental, or intellectual disability, abnormality, or disease

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Physician Assistant (PA)—a licensed health care practitioner who is acting within the scope of practice of his/her respective licensing board(s) and/or certifications.

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AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:685 (April 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 48:

Subchapter C. Pre-Operative, Intra-Operative, and Post-Operative Procedures

§4431. Screening and Pre-Operative Services

A. – E.1. ...

2. Requirements

a. Except as provided in Subparagraph b below, at least 72 hours prior to the pregnant woman having any part of an abortion performed or induced, and prior to the administration of any anesthesia or medication in preparation for the abortion on the pregnant woman, the physician who is to perform the abortion or a qualified person who is the physician’s agent shall comply with all of the following requirements:

i. perform an obstetric ultrasound on the pregnant woman, offer to simultaneously display the screen which depicts the active ultrasound images so that the pregnant woman may view them and make audible the fetal heartbeat, if present, in a quality consistent with current medical practice. Nothing in this Section shall be construed to prevent the pregnant woman from not listening to the sounds detected by the fetal heart monitor, or from not viewing the images displayed on the ultrasound screen;

ii. provide a simultaneous and objectively accurate oral explanation of what the ultrasound is depicting, in a manner understandable to a layperson, which shall include the presence and location of the unborn child within the uterus and the number of unborn children depicted, the dimensions of the unborn child, and the presence of cardiac activity if present and viewable, along with the opportunity for the pregnant woman to ask questions;

iii. offer the pregnant woman the option of requesting an ultrasound photograph or print of her unborn child of a quality consistent with current standard medical practice that accurately portrays, to the extent feasible, the body of the unborn child including limbs, if present and viewable;

iv. from a form that shall be produced and made available by the department, staff will orally read the

statement on the form to the pregnant woman in the ultrasound examination room prior to beginning the ultrasound examination, and obtain from the pregnant woman a copy of a completed, signed, and dated form; and

v. retain copies of the election form and certification prescribed above. The certification shall be placed in the medical file of the woman and shall be kept by the outpatient abortion facility for a period of not less than seven years. If the woman is a minor, the certification shall be placed in the medical file of the minor and kept for at least seven years or for five years after the minor reaches the age of majority, whichever is greater. The woman's medical files shall be kept confidential as provided by law.

b. If the pregnant woman certifies in writing that she currently lives 150 miles or more from the nearest licensed outpatient abortion facility that is willing and able to perform the abortion at the particular woman’s stage of pregnancy, then the physician who is to perform the abortion or a qualified person who is the physician’s agent shall comply with all of the requirements of §4431.E.2.a at least 24 hours prior to the woman having any part of an abortion performed or induced.

c. – e. Repealed.

E.3. - F. ...

G. Information and Informed Consent

1. Oral and Written Information Provided by Physician or Referring Physician

a. Except as provided in Paragraph b below, at least 72 hours before the abortion the physician who is to perform the abortion or the referring physician shall provide informed consent to the pregnant woman seeking an abortion, pursuant to all laws, rules and regulations regarding informed consent. The informed consent shall be communicated both orally and in-person, and in writing, and shall be provided in a private room. Documentation of all such informed consent provided shall be maintained in the patient's medical record.

b. If the woman certifies in writing that she currently lives 150 miles or more from the nearest licensed outpatient abortion facility that is willing and able to perform the abortion at the particular woman's stage of pregnancy, then the physician who is to perform the abortion or the referring physician shall comply with all of the requirements of §4431.G.1 at least 24 hours prior to the abortion.

1.c. - 2.a. ...

3. Oral Information Provided by Physician, Referring Physician, or Qualified Person

a. Except as provided in Subparagraph b below, at least 72 hours before a scheduled abortion the physician who

is to perform the abortion, the referring physician, or a qualified person shall inform the pregnant woman seeking an abortion, orally and in-person that:

i. – iv. ...

b. If the woman certifies in writing that she currently lives 150 miles or more from the nearest licensed outpatient abortion facility that is willing and able to perform the abortion at the particular woman's stage of pregnancy, then the physician who is to perform the abortion the referring physician, or a qualified person shall comply with all of the requirements of §4431.G.3 at least 24 hours prior to the abortion.

4. Provision of Printed Materials

a. At least 72 hours before the abortion, the pregnant woman seeking an abortion shall be given a copy of the printed materials, pursuant to any applicable state laws, rules, and regulations, by the physician who is to perform the abortion, the referring physician, or a qualified person. These printed materials shall include any printed materials necessary for a voluntary and informed consent, pursuant to R.S. 40:1061.17. However, if the pregnant woman certifies in writing that she currently lives 150 miles or more from the nearest licensed outpatient abortion facility that is willing and able to perform the abortion at the particular woman's stage of

pregnancy, she shall be given a copy of the printed materials at least 24 hours prior to an elective abortion procedure by the physician who is to perform the abortion or a qualified person as defined in R.S. 40:1061.17(B)(4)(c).

i. – NOTE Repealed.

b. At least 72 hours before the abortion, the pregnant woman or minor female considering an abortion shall be given a copy of the department's *Point of Rescue* pamphlet and any other materials described in R.S. 40:1061.16 by the physician who is to perform the abortion or a qualified person as defined in R.S. 40:1061.17(B)(4)(c), except in the case of medical emergency defined by applicable state laws. However, if the pregnant woman or minor female considering an abortion certifies in writing that she currently lives 150 miles or more from the nearest licensed outpatient abortion facility that is willing and able to perform the abortion at the particular woman's stage of pregnancy, she shall be given a copy of these printed materials at least 72 hours prior to an elective abortion procedure by the physician who is to perform the abortion or a qualified person as defined in R.S. 40:1061.17(B)(4)(c), except in the case of medical emergency defined by applicable state laws.

i. The physician or qualified person shall provide to the woman, or minor female seeking an abortion, such

printed materials individually and in a private room for the purpose of ensuring that she has an adequate opportunity to ask questions and discuss her individual circumstances.

ii. The physician or qualified person shall obtain the signature of the woman or minor female seeking an abortion on a form certifying that the printed materials were given to the woman or minor female.

iii. In the case of a minor female considering an abortion, if a parent accompanies the minor female to the appointment, the physician or qualified person shall provide to the parent copies of the same materials given to the female.

iv. The signed certification form shall be kept within the medical record of the woman or minor female for a period of at least seven years.

c. At least 72 hours before the abortion, the pregnant woman seeking an abortion shall be given a copy of a printed informational document including resources, programs and services for pregnant women who have a diagnosis of fetal genetic abnormality and resources, programs and services for infants and children born with disabilities. However, if the pregnant woman certifies in writing that she currently lives 150 miles or more from the nearest licensed outpatient abortion facility that is willing and able to perform the abortion at the

particular woman’s stage of pregnancy, she shall be given a copy of these printed materials at least 24 hours prior to an elective abortion procedure by the physician who is to perform abortion or a qualified person as defined in R.S. 40:1061.17(B)(4)(c).

d. If the pregnant woman seeking an abortion is unable to read the materials, the materials shall be read to her. If the pregnant woman seeking an abortion asks questions concerning any of the information or materials, answers shall be provided to her in her own language.

NOTE: The provisions of this Section requiring a physician or qualified person to provide required printed materials to a woman considering an abortion shall become effective 30 days after the department publishes a notice of the availability of such materials.

5. Certification and Reporting

a. Prior to the abortion, the outpatient abortion facility shall ensure the pregnant woman seeking an abortion has certified, in writing on a form provided by the department that the information and materials required were provided at least 72 hours prior to the abortion, or at least 24 hours prior to the abortion in the case of a woman who has given prior certification in writing that she currently lives 150 miles or more from the nearest licensed outpatient abortion facility that is willing and able to perform the abortion at the

particular woman’s stage of pregnancy. This form shall be maintained in the woman’s medical record.

b. ...

c. The pregnant woman seeking an abortion is not required to pay any amount for the abortion procedures until the 72-hour period has expired, or until expiration of the 24-hour period applicable in the case of a woman who has given prior certification in writing that she currently lives 150 miles or more from the nearest licensed outpatient abortion facility that is willing and able to perform the abortion at the particular woman’s stage of pregnancy.

6. – 7.b. ...

8. Disposition of Fetal Remains

a. Each physician who performs or induces an abortion which does not result in a live birth shall ensure that the remains of the fetus are disposed of by interment or cremation, in accordance with the provisions of R.S. 8:651 et seq. and the provisions of LAC 51:XXVI.

b. Prior to an abortion, the physician shall orally and in writing inform the pregnant woman seeking an abortion in the licensed abortion facility that the pregnant woman has the following options:

i. the option to make arrangements for the disposition and/or disposal of fetal remains by interment or

cremation, in accordance with the provisions of R.S. 8:651 et seq.; or

ii. the option to have the outpatient abortion facility/physician make the arrangements for the disposition and/or disposal of fetal remains by interment or cremation, in accordance with the provisions of R.S. 8:651 et seq.

c. The pregnant woman shall sign a consent form attesting that she has been informed of these options; if the pregnant woman wants to make arrangements for the disposition of fetal remains, she will indicate so on the form; if no such indication is made on the form by the pregnant woman, the outpatient abortion facility/physician shall make the arrangements for the disposition and/or disposal of fetal remains by interment or cremation, in accordance with the provisions of R.S. 8:651 et seq.

d. the requirements of §4431.G.8 regarding dispositions of fetal remains, shall not apply to abortions induced by the administration of medications when the evacuation of any human remains occurs at a later time and not in the presence of the inducing physician or at the facility in which the physician administered the inducing medications.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:700 (April 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 48:

Dr. Courtney N. Phillips

Secretary

RULE

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

Home and Community-Based Services Waivers
Children's Choice Waiver
(LAC 50:XXI.11105, 11301, 11303, 11501, 11529, 12101, and 12301)

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:XXI.11105, §11301, §11303, §11501, §11529, §12101, and §12301 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 9. Children's Choice Waiver

Chapter 111. General Provisions

§11105. Money Follows the Person Rebalancing Demonstration

A. - A.1. ...

B. Individuals must meet the following criteria for participation in the MFP Rebalancing demonstration.

1. Individuals with a developmental disability must:

a. ...

b. occupy a licensed, approved and enrolled Medicaid nursing facility bed for at least 60 days or have been hospitalized in an acute care hospital for 60 days with referral for nursing facility placement; and

B.1.c. – E. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 35:1892 (September 2009), amended by Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2524 (December 2017),amended by the Department of Health, Bureau of Health Services Financing, and the Office for the Citizens with Developmental Disabilities, LR 48:

Chapter 113. Service

§11301. Service Cap

A. – D. ...

E. Children’s choice services are capped at $20,200 per individual per plan of care year.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 26:2793 (December 2000), amended LR 28:1787 (August 2002), repromulgated for LAC, LR 28:1983 (September 2002), amended by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2440 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 37:2157 (July 2011), LR 39:507 (March 2013), LR 39:2498 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:

§11303. Service Definitions

A. – D.6. ...

7. Excluded are those adaptations or improvements to the home or vehicle, which are of general utility, and are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning, whole home generators, a fence, etc.

D.8. – E.2. ...

3. For purposes of this service only, “family” is defined as persons who live with or provide care to a participant in the children’s choice waiver and may include a parent, spouse, stepparent, grandparent, child, and sibling, relative, foster

family, legal guardian, or in-law

E.4. – F.1.b. ...

2. Family members who provide family support services must meet the same standards of service, training requirements, and documentation requirements as caregivers who are unrelated to the participant. Service hours shall be capped at 40 hours per week, Sunday to Saturday, for services delivered by family members living in the home.

a. – b. Repealed.

3. Legally responsible individuals (such as a parent or spouse) and legal guardians may provide family support services for their own child, provided that the care is extraordinary in comparison to that of a child of the same age without a disability and the care is in the best interest of the child. Legally responsible individuals and legal guardians may not provide family support services delivered through self-direction.

G. – N.4.a. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 26:2793 (December 2000), repromulgated for LAC, LR 28:1983 (September 2002), amended by the Department of Health and

Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1871 (September 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 36:324 (February 2010), LR 39:2498 (September 2013), LR 40:67 (January 2014), LR 41:126 (January 2015), amended by Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2525 (December 2017), LR 48:

Chapter 115. Provider Participation Requirements

Subchapter A. Provider Qualifications

§11501. Support Coordination Providers and Service Providers

A. – B. ...

1. Family members who provide family support services must meet the same standards of service, training requirements, and documentation requirements as caregivers who are unrelated to the participant.

a. – b. Repealed.

2. Legally responsible individuals (such as a parent or spouse) and legal guardians who provide family support services for their own child must meet the same standards of service, training requirements, and documentation requirements as caregivers who are unrelated to the participant. Monitoring shall be conducted to ensure proper documentation and that the services

are delivered in accordance with the child's plan of care. 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.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 26:2793 (December 2000), repromulgated for LAC, LR 28:1984 (September 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2501 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:

§11529. Professional Services Providers

A. – G. ...

H. Providers of professional services must maintain adequate documentation to support service delivery and compliance with the approved plan of care and provide said documentation upon the LDH's request.

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

HISTORICAL NOTE: Promulgated by the Department of Health

and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2501 (September 2013), amended LR 41:128 (January 2015),amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:

Chapter 121. Reimbursement Methodology

§12101. Unit of Reimbursement

A. – B.1. ...

a. Up to two participants may choose to share family support services if they share a common provider of this service. Family support services may share a direct support worker (DSW) across two waivers: the Residential Options Waiver (community living supports) and/or New Opportunities Waiver (individual and family supports). However, sharing a DSW at the same time across all three waivers is not allowed.

1.b. - 3. ...

4. - 4.a. Repealed.

5. – 5.d.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 of the Secretary, Bureau of Health Services Financing, LR 28:1987 (September 2002), LR 33:1872 (September 2007), amended by the Department of Health and Hospitals, Office

for Citizens with Developmental Disabilities, LR 34:250 (February 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 36:324 (February 2010), LR 36:2280 (October 2010), LR 37:2157 (July 2011), LR 39:2504 (September 2013), LR 40:68 (January 2014), LR 41:128 (January 2015), LR 42:896 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:40 (January 2022), LR 48:

Chapter 123. Self-Direction Initiative

§12301. Self-Direction Service Delivery Option

A. ...

B. Participant Responsibilities. Waiver participants choosing the self-directed service delivery option must understand the rights, risks and responsibilities of managing their own care and individual budget. If the participant is under 18 years of age or is unable to make decisions independently, the participant must have an authorized representative who understands the rights, risks and responsibilities of managing his/her care and supports within the participant's individual budget. The employer must be at least 18 years of age. Responsibilities of the participant or authorized representative include:

1. – 3.b. ...

4. all services rendered shall be prior approved and in accordance with the plan of care;

5. all services must be documented in service notes, which describes the services rendered and progress towards the participant’s personal outcomes plan of care; and

6. authorized representatives may be the employer of the self-directed option, but may not also be the employee.

C. – C.2.d.iv. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, Office for Citizens with Developmental Disabilities, LR 39:2504 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2527 (December 2017), LR 48:

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.

Dr. Courtney N. Phillips

Secretary

RULE

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

Home and Community-Based Services Waivers
New Opportunities Waiver
Dental Services
(LAC 50:XXI.Chapters 137-143)

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities has amended LAC 50:XXI.Chapters 137–143 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 11. New Opportunities Waiver

Chapter 137. General Provisions

§13701. Introduction

A. The New Opportunities Waiver (NOW), hereafter referred to as the NOW, is designed to enhance the home and community-based services and supports available to individuals with developmental disabilities, who would otherwise require an intermediate care facility for persons with developmental

disabilities (ICF-IDD) level of care. The mission of the NOW is to utilize the principle of self-determination and supplement the family and/or community supports while supporting the dignity, quality of life and security in the everyday life of an individual, and maintaining that individual in the community. Services provided in the NOW are community-based, 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, NOW includes a self-direction service delivery option. This allows for greater flexibility in hiring, training, and general service delivery issues.

B. All NOW services are accessed through the case management agency of the beneficiary’s choice. All services must be prior authorized and delivered in accordance with the approved comprehensive plan of care (CPOC). The CPOC shall be developed using a person-centered process coordinated by the beneficiary’s case manager.

C. ...

D. In order for the NOW provider to bill for services, the beneficiary and the direct service provider, professional or

other practitioner rendering service, must be present at the time the service is rendered unless otherwise allowed in rule. The service must be documented in service notes describing the service rendered and progress towards the beneficiary's personal outcomes and CPOC.

E. - E.3.av. ...

F. The average beneficiary expenditures for all waiver services shall not exceed the average Medicaid expenditures for ICF-IDD services.

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 of the Secretary, Bureau of Community Supports and Services, LR 30:1201 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1647 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:68 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:50 (January 2018), LR 45:42 (January 2019), LR 46:1680 (December 2020), LR 48:

§13702. Settings for Home and Community-Based Services

A. NOW beneficiaries are expected to be integrated in and have full access to the greater community while receiving services, to the same extent as individuals without disabilities. Providers shall meet the requirements of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' (CMS) home and community-based setting requirements for Home and Community-Based Services (HCBS) Waivers as delineated in LAC 50:XXI.901.

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 44:51 (January 2018), LR 48:

§13703. Beneficiary Qualifications and Admissions Criteria

A. In order to qualify for the New Opportunities Waiver (NOW), an individual must be three years of age or older and meet all of the following criteria:

1. – 3. ...

4. meet the requirements for an ICF-IDD level of care which requires active treatment of a developmental disability under the supervision of a qualified developmental disability professional;

5. – 8. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1201 (June 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:96 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2528 (December 2017), LR 45:43 (January 2019), LR 48:

§13704. Needs-Based Assessment

A. A uniform needs-based assessment in conjunction with person-centered planning is utilized in the service planning process for the individuals receiving or participating in an OCDD waiver. The results of this assessment activity shall be utilized to determine which OCDD waiver will be offered to the individual during the initial plan of care process.

1. The beneficiary or his/her representative may request a reconsideration and present supporting documentation if he/she disagrees with the specific OCDD waiver offered as a result of the needs based assessment and person-centered planning process. If the beneficiary disagrees with the

reconsideration decision, he/she may request a fair hearing through the formal appeals process.

B. – C.4.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 Service Financing and the Office for Citizens with Developmental Disabilities, LR 36:65 (January 2010), amended LR 40:69 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2528 (December 2017), LR 48:

§13705. Denial of Admission or Discharge Criteria

A. Individuals shall be denied admission to or discharged from the NOW if one of the following criteria is met:

1. ...

2. the individual does not meet the requirement for an ICF-IDD level of care;

3. - 4. ...

5. the beneficiary is admitted to an ICF-IDD facility or nursing facility with the intent to stay and not to return to waiver services. The waiver beneficiary may return to waiver services when documentation is received from the treating physician that the admission is temporary and shall not exceed

90 days. The beneficiary will be discharged from the waiver on the ninety-first day if the beneficiary is still in the ICF-IDD or nursing facility;

6. the health and welfare of the beneficiary cannot be assured through the provision of NOW services within the beneficiary's approved comprehensive plan of care;

7. ...

8. continuity of services is interrupted as a result of the individual not receiving a NOW service during a period of 30 or more consecutive days. This does not include interruptions in NOW services because of hospitalization, temporary admission to rehabilitation or nursing facilities, or non-routine lapses in services where the family agrees to provide all needed or paid natural supports. There must be documentation from the treating physician that this interruption will not exceed 90 days in the case of the admission to a rehabilitation or nursing facility. During this 90-day period, the Office for Citizens with Developmental Disabilities (OCDD) will not authorize payment for NOW services; and/or

9. there is no justification, based on a uniform needs-based assessment and a person-centered planning discussion, that the NOW is the only OCDD waiver that will meet the beneficiary's needs.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1202 (June 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities LR 40:69 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:51 (January 2018), LR 45:43 (January 2019), LR 48:

§13706. Resource Allocation

A. ...

1. The beneficiary or his/her representative may request a reconsideration and present supporting documentation if he/she disagrees with the amount of assigned IFS service units. If the beneficiary disagrees with the reconsideration decision, he/she may request a fair hearing through the formal appeals process.

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, Bureau of Health Service Financing and the Office for Citizens

with Developmental Disabilities, LR 43:2528 (December 2017), LR 48:

§13707. Programmatic Allocation of Waiver Opportunities

A. The intellectual/developmental disabilities request for services registry, hereafter referred to as “the registry,” is the list that documents and maintains the person’s name and protected request date for waiver services. A person’s protected request date for any OCDD waiver is the date of the first face–to-face interview in which he/she applied for waiver services and is determined eligible for developmental disabilities services by the entry unit. The order of entry into an OCDD waiver is needs based from the registry arranged by an urgency of need assessment and date of application for developmentally disabled (DD) waiver services.

B. Funded OCDD waiver opportunities shall be offered based on the following priority groups:

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

Individuals requesting to transition from a publicly operated ICF-IDD 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. The funded waiver opportunity will be reserved for a period not to exceed 120 days; however, this 120-day period may be extended as needed.

2. individuals on the registry who have a current unmet need as defined by a screening for urgency of need (SUN) score of (three) urgent or (four) emergent and the earliest registry date shall be notified in writing when a funded OCDD waiver opportunity is available.

C. The Office for Citizens with Developmental Disabilities has the responsibility to monitor the utilization of NOW opportunities. At the discretion of the OCDD, specifically allocated waiver opportunities may be reallocated, to better meet the needs of citizens with developmental disabilities in the state of Louisiana.

1. – 2. Repealed.

D. Funded waiver opportunities will only be allocated to individuals who successfully complete the financial and medical eligibility process required for waiver certification.

E. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 31:2900 (November 2005), amended LR 33:2440 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 37:3526 (December 2011), LR 40:70 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2529 (December 2017), LR 48:

Chapter 139. Covered Services

§13901. Individual and Family Support Services

A. Individual family support (IFS) services are direct support and assistance services, provided in the beneficiary's home or in the community, that allow the beneficiary to achieve and/or maintain increased independence, productivity, enhanced family functioning and inclusion in the community to the same degree as individuals without disabilities. IFS services are also used to provide relief to the primary caregiver. Transportation is included in the reimbursement for these services. Reimbursement for these services includes the

development of a service plan for the provision of these services, based on the approved COPC.

1. Individual and family support day (IFS-D) services will be authorized during waking hours for up to 16 hours when natural supports are unavailable in order to provide continuity of services to the beneficiary. Waking hours are the period of time when the beneficiary is awake and not limited to traditional daytime hours as outlined in the CPOC.

a. ...

2. Individual family support-night (IFS-N) service is direct support and assistance provided during the beneficiary's sleeping "night" hours. Night hours are considered to be the period of time when the beneficiary is asleep and there is a reduced frequency and intensity of required assistance. IFS-N services are not limited to traditional nighttime hours and are outlined in the CPOC. The IFS-N worker must be immediately available and in the same residence as the beneficiary to be able to respond to the beneficiary's immediate needs. Documentation of the level of support needed, based on the frequency and intensity of needs, shall be included in the CPOC with supporting documentation in the provider's services plan. Supporting documentation shall outline the beneficiary's safety, communication, and response methodology planned for and agreed to by the beneficiary and/or his/her authorized

representative identified in his/her circle of support. The IFS-N worker is expected to remain awake and alert unless otherwise authorized under the procedures noted below.

a. Beneficiaries who are able during sleeping hours to notify direct support workers of his/her need for assistance may choose the option of IFS-N services where staff is not required to remain awake.

b. The beneficiary’s support team shall assess the beneficiary’s ability to awaken staff. If it is determined that the beneficiary is able to awaken staff and requests that the IFS-N worker be allowed to sleep, the CPOC shall reflect the beneficiary’s request.

c. Support teams should consider the use of technological devices that would enable the beneficiary to notify/awaken IFS-N staff. (Examples of devices include wireless pagers, alerting devices such as a buzzer, a bell or a monitoring system.) If the method of awakening the IFS-N worker utilizes technological device(s), the service provider will document competency in use of devices by both the beneficiary and IFS-N staff prior to implementation. The support coordinator will require a demonstration of effectiveness of this service no less than quarterly.

d. A review shall include review of log notes indicating instances when IFS-N staff was awakened to attend to

the beneficiary. Also included in the review is acknowledgement by the beneficiary that IFS-N staff responded to his/her need for assistance timely and appropriately. Instances when staff did not respond appropriately will immediately be brought to the support team for discontinuation of allowance of the staff to sleep. The service will continue to be provided by awake and alert staff.

e. ...

B. IFS services may be shared by up to three waiver beneficiaries who may or may not live together and who have a common direct service provider agency. Waiver beneficiaries may share IFS services staff when agreed to by the beneficiaries and health and welfare can be assured for each beneficiary. The decision to share staff must be reflected on the CPOC and based on an individual-by-individual determination and choice. Reimbursement rates are adjusted accordingly. Shared IFS services, hereafter referred to as shared support services, may be either day or night services. In addition, IFS direct support may be shared across the Children’s Choice Waiver or the Residential Options Waiver at the same time.

C. IFS (day or night) services include:

1. – 5. ...

6. accompanying the beneficiary to the hospital and remaining until admission or a responsible representative

arrives, whichever occurs first. IFS services may resume at the time of discharge.

D. Exclusions. The following exclusions apply to IFS services.

1. IFS-D services and IFS-N services will not be authorized or provided to the beneficiary while the beneficiary is in a center-based respite facility.

2. IFS-D and IFS-N services will not be authorized or provided to the beneficiary while the beneficiary is receiving monitored in-home caregiving services.

3. Beneficiaries receiving adult companion care services are not eligible to receive individual family support services.

E. Staffing Criteria and Limitations

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

2. Legally responsible individuals (such as a parent or spouse) and legal guardians may provide individual and family support 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.

3. Repealed.

F. – 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 of the Secretary, Bureau of Community Supports and Services, LR 30:1202 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:2063 (November 2006), LR 33:1647 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:71 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:51 (January 2018), LR 48:

§13902 Individual and Family Support Supplemental Payments

A. – B.2.b.ii. ...

C. The supplemental payment is not allowed for waiver beneficiaries who do not receive individual and family support (IFS) services.

D. The supplemental payment may not be approved for waiver beneficiaries receiving IFS hours in addition to 12 or more hours of skilled nursing per day.

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 46:1681 (December 2020), LR 48:

§13903. Center-Based Respite Care

A. Center-based respite (CBR) care is temporary, short-term care provided to a beneficiary with developmental disabilities who requires support and/or supervision in his/her day-to-day life due to the absence or relief of the primary caregiver. While receiving center-based respite care, the beneficiary’s routine is maintained in order to attend school, work or other community activities/outings. The respite center is responsible for providing transportation for community outings, as that is included as part of its reimbursement.

B. Exclusions

1. Individual family support services (both day and night) may not be provided and will not be reimbursed while the beneficiary is in a center–based respite facility.

2. Monitored in home caregiving, adult companion care, and supported independent living services cannot be reimbursed while the beneficiary is in a center-based respite facility.

3. The cost of room and board cannot be claimed except when provided as part of respite care furnished in a facility approved by the state that is not a private residence.

C. Service Limits. CBR services shall not exceed 720 hours per beneficiary, per CPOC year.

1. Beneficiaries may request approval of hours in excess of 720 hours. The request must be submitted to the OCDD central office with proper justification and documentation for prior approval.

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 of the Secretary, Bureau of Community Supports and Services, LR 30:1203 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1648 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:72 (January

2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:51 (January 2018), LR 48:

§13905. Community Life Engagement Development

A. Community life engagement development (CLE) facilitates the development of opportunities to assist beneficiaries in becoming involved in the community through the creation of natural supports. The purpose of CLE is to encourage and foster the development of meaningful relationships in the community reflecting the beneficiary’s choices and values. Objectives outlined in the comprehensive plan of care will afford opportunities to increase community inclusion, participation in leisure/recreational activities, and encourage participation in volunteer and civic activities. Reimbursement for this service includes the development of a service plan. To utilize this service, the beneficiary may or may not be present as identified in the approved CLE service plan. CLE services may be performed by a shared supports worker for up to three waiver beneficiaries who have a common direct service provider agency. Rates shall be adjusted accordingly.

B. Transportation costs are included in the reimbursement for CLE services.

C. Service Limitations. Services shall not exceed 60 hours per beneficiary per CPOC year which includes the

combination of shared and non-shared community integration development.

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 of the Secretary, Bureau of Community Supports and Services, LR 30:1203 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1648 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:72 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:52 (January 2018), LR 48:

§13907. Supported Independent Living

A. Supported independent living (SIL) assists the beneficiary to acquire, improve or maintain those social and adaptive skills necessary to enable a beneficiary to reside in the community and to participate as independently as possible. SIL services include assistance and/or training in the performance of tasks such as personal grooming, housekeeping and money management. Payment for this service includes oversight

and administration and the development of service plans for the enhancement of socialization with age-appropriate activities that provide enrichment and may promote wellness. The service plan should include initial, introduction, and exploration for positive outcomes for the beneficiary for community integration and development. These services also assist the beneficiary in obtaining financial aid, housing, advocacy and self-advocacy training as appropriate, emergency support, trained staff and assisting the beneficiary in accessing other programs for which he/she qualifies. SIL beneficiaries must be 18 years or older.

B. Place of Service. Services are provided in the beneficiary’s residence and/or in the community. The beneficiary’s residence includes his/her apartment or house, provided that he/she does not live in the residence of any legally responsible relative. An exception will be considered when the beneficiary lives in the residence of a spouse or disabled parent, or a parent aged 70 years or older. Family members who are not legally responsible relatives can be SIL workers provided they meet the same qualifications as any other SIL worker. A legally responsible relative is defined as a parent of a minor child, foster parent, curator, tutor, legal guardian, or the beneficiary’s spouse.

C. Exclusions

1. ...

2. SIL shall not include the cost of:

a. – b. ...

c. home maintenance, or upkeep, improvement, modifications, or adaption to a home, or to meet the requirements of the applicable life safety code;

2.d. – 3. ...

4. Beneficiaries receiving adult companion care services are not eligible to receive supported independent living services.

5. Monitored in-home-caregiving services cannot be provided at the same time or on the same day as supported independent living.

D. Service Limit. SIL services are limited to one service per day, per CPOC year, except when the beneficiary is in center-based respite. When a beneficiary living in an SIL setting is admitted to a center-based respite facility, the SIL provider shall not bill the SIL per diem beginning with the date of admission to the center-based respite facility and through the date of discharge from the center-based respite facility.

E. ...

F. Provider Responsibilities

1. Minimum direct services by the SIL agency include two documented contacts per week and one documented face-to-face contact per month by the SIL provider agency in addition to the

approved direct support hours. These required contacts must be completed by the SIL agency supervisor so designated by the provider agency due to the experience and expertise relating to the beneficiary's needs or a licensed/certified professional qualified in the state of Louisiana who meets requirements as defined by 42 CFR §483.430 or any subsequent regulation.

2. – 3. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1204 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1648 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:73 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:52 (January 2018), LR 48:

§13909. Substitute Family Care

A. Substitute family care (SFC) provides for day programming, transportation, independent living training, community integration, homemaker, chore, attendant care and

companion services, and medication oversight (to the extent permitted under state law) to beneficiaries residing in a substitute family care home that meets all licensing requirements for the substitute family care module. The service is a stand-alone family living arrangement for beneficiaries aged 18 years and older. The SFC house parents assume the direct responsibility for the beneficiary’s physical, social, and emotional well-being and growth, including family ties. Only two SFC beneficiaries may reside in a single SFC setting at the same time. There shall be no more than three persons living in a substitute family care setting who are unrelated to the SFC provider. Immediate family members (mother, father, brother and/or sister) cannot be substitute family care parents. Reimbursement for this service includes the development of a service plan based on the approved CPOC. Beneficiaries living in an SFC home may receive IFS services.

B. ...

C. Exclusions

1. Beneficiaries receiving adult companion care services are not eligible to receive substitute family care services.

2. Payments may not be made for room and board, items of comfort or convenience, or the cost of facility maintenance, upkeep, or improvement.

3. Payments may not be made directly or indirectly to members of the beneficiary's immediate family.

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 of the Secretary, Bureau of Community Supports and Services, LR 30:1204 (June 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:73 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:52 (January 2018), LR 48:

§13911. Day Habilitation

A. Day habilitation is provided in a community-based setting and provides the beneficiary assistance with social and adaptive skills necessary to enable the beneficiary to participate as independently as possible in the community. These services focus on socialization with meaningful age-appropriate activities which provide enrichment and promote wellness, as indicated in the beneficiary's CPOC. Day habilitation services are provided in a variety of community settings, (i.e., local recreation department, garden clubs, libraries, etc.) other than

the person’s residence, except for virtual habilitation services, and are not limited to a fixed-site facility.

1. Day habilitation services must be directed by a person-centered service plan and provide the beneficiary choice in how they spend their day. The activities should assist the beneficiary to gain their desired community living experience, including the acquisition, retention or improvement in self-help, socialization and adaptive skills, and/or to provide the individual an opportunity to contribute to and be a part of his or her community.

2. Day habilitation services shall be coordinated with any therapy, prevocational service, or supported employment models that the beneficiary may be receiving. The beneficiary does not receive payment for the activities in which he/she are engaged. The beneficiary must be 18 years of age or older in order to receive day habilitation services.

3. Career planning activities may be a component of the beneficiary’s plan and may be used to develop learning opportunities and career options consistent with the person’s skills and interests.

B. Day Habilitation may be delivered in a combination of these three service types:

1. onsite day habilitation

2. community life engagement

3. virtual day habilitation

C. Day Habilitation is provided on a regularly scheduled basis and may be scheduled on a plan of care for one or more days per week and may be prior authorized for up to 8,320 units of service in a plan of care year. A standard unit of service is a 15-minute increment.

D. Licensing Requirements. Providers must be licensed by the Department of Health and as a home and community-based services provider and must meet the module specific requirements for the service being provided.

E. Service Limitations

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

2. All virtual day habilitation services must be approved by the local governing entity or the OCDD state office.

3. Community life engagement cannot be delivered at the same time as any other service.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1204 (June 2004), amended by the Department of Health and Hospitals, Bureau of Health Services

Financing and the Office for Citizens with Developmental Disabilities, LR 40:73 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:53 (January 2018), LR 48:

§13913. Supported Employment

A. Supported employment is competitive work in an integrated work setting, or employment in an integrated work setting in which the beneficiaries are working toward competitive work that is consistent with the strengths, resources, priorities, interests, and informed choice of beneficiaries for whom competitive employment has not traditionally occurred. The beneficiary must be eligible and assessed to need the service in order to receive supported employment services. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which an individual is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

B. ...

C. Supported employment is conducted in a variety of settings, particularly work sites in which persons without

disabilities are employed. Supported employment cannot be provided at worksites that are facility based, or other similar types of vocational services furnished in specialized facilities that are not part of the general workplace. Supported employment includes activities needed by waiver beneficiaries to sustain paid work, including supervision and training and is based on an individualized service plan. Supported employment may include assistance and prompting with:

1. – 8. ...

D. Supported Employment Models. Reimbursement for supported employment includes an individualized service plan for each model.

1. Individual supported employment one-to-one services include all aspects of the supported employment, process including assessments, development, placement, job retention, and stabilization that are necessary to get an individual to work in an individual competitive job in the community.

2. Follow-along support services provide ongoing supports to individuals and their employers who need the support to maintain their job in integrated work settings in the general workforce. The amount of support is determined for each individual based on the individual’s ability to be independent in the job. Follow-along services may be delivered virtually.

3. Group employment is an employment setting in which a group of two to eight beneficiaries work to complete jobs in a variety of locations in the community under the supervision of an employment specialist in a manner that promotes integration into the workplace and interaction between beneficiaries and people without disabilities in those workplaces that are in the community.

E. Service Exclusions

1. Supported employment services shall not be used in conjunction or simultaneously with any other waiver service, except substitute family care, supported independent living, and skilled nursing services. Virtual follow-along supported employment services cannot be utilized at the same time as any other service.

2. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by beneficiaries receiving waiver services as a result of his/her disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

3. Supported employment services are not available to beneficiaries who are eligible to participate in programs funded under section 110 of the Rehabilitation Act of 1973 or

sections 602(16) and (17) of the Individuals with Disabilities Education Act [20 U.S.C. 1401(26) and (29), as amended, and those covered under the Medicaid State Plan, if applicable.

F. Service Limits

1. Individual supported employment one-to-one services shall not exceed 2,880 one-quarter hour units (15 minute increments) per CPOC year.

2. Both individual and virtual supported employment follow-along services shall not exceed 960 one-quarter hour units (15 minute increments) per CPOC year.

3. Group supported employment services shall not exceed 8,320 one-quarter hour units of service per CPOC year, without additional documentation and approval.

4. All virtual supported employment services must be approved by the local governing entity or the OCDD state office.

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 of the Secretary, Bureau of Community Supports and Services, LR 30:1205 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and

Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:74 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:53 (January 2018), LR 48:

§13915. Transportation for Day Habilitation and Supported Employment Models

A. Transportation provided for the beneficiary to the site of the day habilitation or supported employment model, or between the day habilitation and supported employment model site (if the beneficiary receives services in more than one place) is reimbursable when day habilitation or supported employment model has been provided. Reimbursement may be made for a one-way trip. There is a maximum fee per day that can be charged for transportation regardless of the number of trips per day.

1. Transportation is included in the group supported employment service rate when traveling between job sites.

2. Transportation is a separate billable service if criteria is met. One rate covers regular transportation, and a separate rate covers wheelchair transportation.

3. Transportation may be provided to and/or from the beneficiary’s residence or a location agreed upon by the beneficiary or authorized representative to the onsite location or community location and a separate return trip.

B. Licensing Requirements. Providers must be licensed by the Department of Health as a home and community- based services provider and meet the module specific requirements for the service being provided. The provider must have insurance coverage on any vehicles used in transporting a beneficiary that meets current home and community-based services providers licensing standards.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1205 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:2064 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:74 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:54 (January 2018), LR 48:

§13917. Prevocational Services

A. Prevocational services are individualized, person centered services that assist the beneficiary 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 an individual job in the community but 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.

1. – 2. Repealed.

B. Prevocational services may be delivered in a combination of these three service types:

1. onsite prevocational services

2. community career planning

3. virtual prevocational services

C. Prevocational services are to be provided in a variety of locations in the community and are not to be limited to a fixed site facility. Activities associated with prevocational services should focus on preparing the beneficiary for integrated individual employment in the community. These services are operated through a provider agency that is licensed by the appropriate state licensing agency. Beneficiaries receiving prevocational services must participate in activities designed to establish an employment related goal as part their CPOC. Prevocational services are designed to help create a path to integrated community-based employment for which a beneficiary

is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

1. Repealed.

D. Prevocational services are provided on a regularly scheduled basis and may be scheduled on a comprehensive plan of care for one or more days per week and may be prior authorized for up to 8,320 units of service in a plan year with appropriate documentation. A standard unit is one-quarter hour (15 minute increment).

E. Exclusions. The following service exclusions apply to prevocational services.

1. Prevocational services are not available to beneficiaries who are eligible to participate in programs funded under section 110 of the Rehabilitation Act of 1973 or sections 602(16) and (17) of the Individuals with Disabilities Education Act, [20 U.S.C. 1401(26) and (29)], as amended, and covered under the Medicaid State Plan, if applicable.

2. Prevocational services cannot be provided or billed during the same hours on the same day as other services.

3. All virtual prevocational services must be approved by the local governing entity or the OCDD state office.

4. Transportation is billed as a separate service.

F. Service Limits

1. Prevocational services cannot exceed 8,320 one-quarter hour units of service per CPOC year.

2. On-site prevocational and community career planning services are time limited and individually based with employment at the individual’s highest level of work in the most integrated setting in the community while following applicable federal wage guidelines. Beneficiaries may choose to leave this service at any time or seek employment at any time.

3. Through permission from the local governing entity, a person may complete this service more than once.

G. Licensing Requirements. Providers must be licensed by the Department of Health as a home and community-based services provider and must meet the module specific requirements for the service being provided.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1205 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office

for Citizens with Developmental Disabilities, LR 40:75 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:55 (January 2018), LR 48:

§13919. Environmental Accessibility Adaptations

A. Environmental accessibility adaptations are physical adaptations to the home or a vehicle that are necessary to ensure the health, welfare, and safety of the beneficiary or that enable him/her to function with greater independence in the home and/or community. Without these services, the beneficiary would require additional supports or institutionalization.

B. Such adaptations may include:

1. – 3. ...

4. installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies for the welfare of the beneficiary; or

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

C. ...

1. Any service covered under the Medicaid state plan shall not be authorized by NOW. The environmental accessibility adaptation(s) must be delivered, installed, operational and accepted by the beneficiary/authorized representative in the

CPOC year for which it was approved. The environmental accessibility adaptation(s) must be billed and reimbursed according to the Medicaid billing guidelines established by LDH policy. A written itemized detailed bid, including drawings with the dimensions of the existing and proposed floor plans relating to the modification, must be obtained and submitted for prior authorization. Modifications may be applied to rental or leased property with the written approval of the landlord and approval of the human services authority or district. Reimbursement shall not be paid until receipt of written documentation that the job has been completed to the satisfaction of the beneficiary.

2. 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 from manufacturers.

3. Excluded are those adaptations or improvements to the residence that are of general utility or maintenance and are not of direct medical or remedial benefit to the beneficiary, including, but not limited to:

a. air conditioning or heating;

b. flooring;

c. roofing, installation or repairs;

d. smoke and carbon monoxide detectors, sprinklers, fire extinguishers, or hose; or

e. furniture or appliances; or

f. whole home generators.

4. ...

5. Home modification funds are not intended to cover basic construction cost. For example, funds may be used to cover the difference between constructing a bathroom and building an accessible or modified bathroom, but in any situation funds must be used to pay for a specific approved adaptation.

6. ...

D. Service Limits. There is a cap of $7,000 per three-year period for a beneficiary for environmental accessibility adaptations. On a case-by-case basis, with supporting documentation and based on need, a beneficiary may be able to exceed this cap with the prior approval of OCDD central office.

E. – E.2. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1206 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office

for Citizens with Developmental Disabilities, LR 40:75 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:55 (January 2018), LR 48:

§13921. Specialized Medical Equipment and Supplies

A. Specialized medical equipment and supplies (SMES) are devices, controls, or appliances which enable the beneficiary to:

1. – 3. ...

B. The service includes medically necessary durable and nondurable medical equipment not covered under the Medicaid state plan. NOW does not cover non-medically necessary items. All items shall meet applicable standards of manufacture, design and installation. Routine maintenance or repair of specialized medical equipment is funded under this service.

C. All alternate funding sources that are available to the beneficiary shall be pursued before a request for the purchase or lease of specialized equipment and supplies will be considered.

D. Exclusion. Excluded are specialized equipment and supplies that are of general utility or maintenance, but are not of direct medical or remedial benefit to the beneficiary. Excluded also are those durable and non-durable items that are available under the Medicaid State Plan.

E. Service Limitations. There is a cap of $1,000 per three year period for a beneficiary for specialized equipment and supplies. On a case-by-case basis, with supporting documentation and based on need, a beneficiary may be able to exceed this cap with the prior approval of OCDD central office.

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 of the Secretary, Bureau of Community Supports and Services, LR 30:1207 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:75 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:56 (January 2018), LR 48:

§13923. Personal Emergency Response Systems

A. Personal emergency response systems (PERS) is a rented electronic device connected to the person's phone and programmed to signal a response center which enables a beneficiary to secure help in an emergency.

B. Beneficiary Qualifications. Personal emergency response systems (PERS) services are available to those persons who:

1. – 3. ...

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.

D. ...

E. Provider Qualifications. The provider must be an enrolled Medicaid provider of the PERS. The provider shall install and support PERS equipment in compliance with all applicable federal, state, parish and local laws and meet manufacturer’s specifications, response requirements, maintenance records and beneficiary education.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1207 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1650 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:76 (January

2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:

§13925. Professional Services

A. Professional services are services designed to increase the beneficiary's independence, participation and productivity in the home, work and community. Beneficiaries, up to the age of 21, who participate in NOW must access these services through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Professional services may only be furnished and reimbursed through NOW when the services are not covered under the Medicaid State Plan. Professional services must be delivered with the beneficiary present and be provided based on the approved CPOC and an individualized service plan. Service intensity, frequency and duration will be determined by individual need. Professional services may be utilized to:

1. – 2. ...

3. provide training or therapy to a beneficiary and/or his/her natural and formal supports necessary to either develop critical skills that may be self-managed by the beneficiary or maintained according to the beneficiary's needs;

4. ...

5. provide necessary information to the beneficiary, family, caregivers and/or team to assist in the implementation of plans according to the approved CPOC.

B. Professional services are limited to the following services.

1. Psychological services are direct services performed by a licensed psychologist, as specified by state law and licensure. These services are for the treatment of a behavioral or mental condition that addresses personal outcomes and goals desired by the and his/her team. Services must be reasonable and necessary to preserve and improve or maintain adaptive behaviors or decrease maladaptive behaviors of a person with developmental disabilities. Service intensity, frequency, and duration will be determined by individual need.

2. – 3. ...

C. Service Limits. There shall be a $2,250 cap per beneficiary per CPOC year for the combined range of professional services in the same day but not at the same time. Additional services may be prior authorized if the beneficiary reaches the cap before the expiration of the comprehensive plan of care and the beneficiary’s health and safety are at risk. One or more professional services may be utilized in the same day, but not at the same time.

D. – E.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, Bureau of Community Supports and Services, LR 30:1207 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1650 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:76 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:56 (January 2018), LR 48:

§13927. Skilled Nursing Services

A. Skilled nursing services are medically necessary nursing services ordered by a physician and provided by a licensed registered nurse, nurse practitioner, or a licensed practical nurse working under the supervision of a registered nurse. Skilled nursing services shall be provided by a licensed, enrolled home health agency and require an individual nursing service plan. These services must be included in the beneficiary’s approved CPOC. All available Medicaid State Plan skilled nursing services must be exhausted before accessing this service. Beneficiaries, up to the age of 21, must access these

services as outlined on the CPOC through the Home Health Program in the Medicaid State Plan pursuant to the EPSDT benefit.

B. When there is more than one beneficiary in the home receiving skilled nursing services, services may be shared and payment must be coordinated with the service authorization system and each beneficiary approved CPOC. Nursing consultations are offered on an individual basis only.

C. ...

D. Monitored in-home caregiving services cannot be provided at the same time or on the same day as skilled nursing services.

E. All requests for over 12 hours of skilled nursing per day must be reviewed and approved by the LDH medical director and medical evaluation team.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1208 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1651 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:77 (January

2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:56 (January 2018), LR 46:1681 (December 2020), LR 48:

§13929. One-Time Transitional Expenses

A. One-time transitional expenses are those allowable one-time, set-up expenses incurred by beneficiaries who are being transitioned from an ICF-DD to his/her own home or apartment of their choice in the community of their choice. *Own home* shall mean the beneficiary's own place of residence and does not include any family members' home or substitute family care homes. The beneficiaries must be allowed choice in the items purchased.

B. Allowable transitional expenses include:

1. the purchase of essential furnishings, such as:

a. bedroom and living room furniture,

b. dining table and chairs,

c. window blinds,

d. eating utensils, and

e. ...

2. – 3. ...

4. non-refundable security deposits required to obtain a lease on an apartment or home and set-up fees for utilities.

C. Service Limits. Set-up expenses are capped at $3,000 over a beneficiary's lifetime.

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, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1208 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1651 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:77 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:56 (January 2018), LR 48:

§13931. Adult Companion Care

A. Adult companion care services assist the beneficiary to achieve and/or maintain the outcomes of increased independence, productivity and inclusion in the community. These services are designed for an individual who lives independently and can manage his/her own household with limited supports. The companion is a principal care provider chosen by the beneficiary, who provides services in the beneficiary's home.

The companion must be at least 18 years of age and lives with the beneficiary as a roommate. Adult companion care services are furnished through a licensed provider organization as outlined in the beneficiary's CPOC. This service includes:

1. providing assistance with all of the activities of daily living as indicated in the beneficiary's CPOC;

2. – 3. ...

B. Adult companion care services are arranged by provider organizations that are subject to licensure. The setting is the beneficiary's home which should have been freely chosen by the beneficiary from among non-disability specific settings and not owned or controlled by the provider. The companion is an employee or contractor of the provider organization and is responsible for providing limited, daily direct services to the beneficiary.

1. ...

2. Services may not be provided by a family member who is a legally responsible individual, such as the beneficiary's spouse, or a legal guardian.

C. Provider Responsibilities

1. The provider organization shall develop a written agreement as part of the beneficiary CPOC which defines all of the shared responsibilities between the companion and the

beneficiary. The written agreement shall include, but is not limited to:

a. – c. ...

2. Repealed.

3. The provider organization is responsible for performing the following functions which are included in the daily rate:

a. ...

b. making an initial home visit to the beneficiary home, as well as periodic home visits as required by the department;

c. contacting the companion a minimum of once per week or as specified in the beneficiary’s comprehensive plan of care; and

d. ...

4. The provider shall facilitate a signed written agreement between the companion and the beneficiary which assures that:

a. ...

b. inclusion of any other expenses must be negotiated between the beneficiary and the companion. These negotiations must be facilitated by the provider and the resulting agreement must be included in the written agreement and in the beneficiary’s CPOC.

D. Companion Responsibilities

1. – 1.c. ...

2. The companion is an employee of the provider agency and is paid a flat daily rate to provide adult companion care services as included in the approved CPOC.

3. The companion is responsible for meeting all financial obligations as agreed upon in the agreement between the provider agency, the beneficiary, and the companion.

E. Service Limits

1. Adult companion care services may be authorized for up to 365 days per year as documented in the beneficiary's CPOC.

F. Service Exclusions

1. Adult companion care services cannot be provided or billed for at the same time as center-based respite care services.

2. Beneficiaries receiving adult companion care services are not eligible for receiving the following services:

a. – b. ...

c. substitute family care;

d. skilled nursing; or

e. monitored in-home caregiving (MIHC)

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, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:77 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:57 (January 2018), repromulgated LR 44:282 (February 2018), LR 48:

§13935. Housing Stabilization Transition Service

A. Housing stabilization transition service enables beneficiaries who are transitioning into a permanent supportive housing unit, including those transitioning from institutions, to secure their own housing. The service is provided while the beneficiary is in an institution and preparing to exit the institution using the waiver. The setting for the permanent supportive housing must be integrated in the greater community, and support full access to the greater community by the beneficiary. The service includes the following components:

1. conducting a housing assessment to identify the beneficiary’s preferences related to housing (i.e., type, location, living alone or with someone else, accommodations needed, and other important preferences), and his/her needs for support to maintain housing, including:

a. access to housing of the beneficiary's choice, including non-disability specific settings;

b. – h. ...

2. assisting the beneficiary to view and secure housing as needed. This may include arranging or providing transportation. The beneficiary shall be assisted in securing supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings;

3. developing an individualized housing support plan based upon the housing assessment that:

a. ...

b. establishes the beneficiary's approach to meeting the goal; and

A.3.c. – B. ...

C. Beneficiaries may not exceed 165 combined units of this service and the housing stabilization service.

1. ...

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 40:78 (January 2014), amended by the Department of Health, Bureau of

Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:57 (January 2018), LR 48:

§13937. Housing Stabilization Service

A. Housing stabilization service enables waiver beneficiaries to maintain their own housing as set forth in the beneficiary's approved CPOC. Services must be provided in the home or a community setting. This service includes the following components:

1. conducting a housing assessment to identify the beneficiary's preferences related to housing (i.e., type, location, living alone or with someone else, accommodations needed, and other important preferences), and his/her needs for support to maintain housing, including:

a. – h. ...

2. assisting the beneficiary to view and secure housing as needed. This may include arranging or providing transportation. The beneficiary shall be assisted in securing supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings;

3. developing an individualized housing stabilization service provider plan based upon the housing assessment that includes short and long-term measurable goals for each issue, establishes the beneficiary's approach to meeting the goal, and identifies where other provider(s) or

services may be required to meet the goal. This includes updating the housing support plan annually or as needed due to changes in the beneficiary's situation or status;

4. participating in the development of the CPOC, incorporating elements of the housing stabilization service provider plan. This includes participation in plan of care renewals and updates as needed;

5. providing supports and interventions according to the individualized stabilization service provider plan. If additional supports or services are identified as needed outside the scope of housing stabilization service, the needs must be communicated to the support coordinator;

6. providing ongoing communication with the landlord or property manager regarding the beneficiary's disability, accommodations needed, and components of emergency procedures involving the landlord or property manager; and

7. if at any time the beneficiary's housing is placed at risk (e.g., eviction, loss of roommate or income), housing stabilization service will provide supports to retain housing or locate and secure housing to continue community-based supports, including locating new housing, sources of income, etc.

B. This service is only available upon referral from the support coordinator and the service is not duplicative of other

waiver services including support coordination. It is only available to persons who are residing in a state of Louisiana permanent supportive housing unit or who are linked for a state of Louisiana permanent supportive housing unit.

C. Beneficiaries may not exceed 165 combined units of this service and the housing stabilization transition service.

1. ...

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 40:79 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:57 (January 2018), LR 48:

§13939. Monitored In-Home Caregiving Services

A. Monitored in-home caregiving (MIHC) services are provided by a principal caregiver to a beneficiary who lives in a private unlicensed residence.

1. The goal of this service is to provide a community-based option that provides continuous care, supports, and professional oversight.

2. This goal is achieved by promoting a cooperative relationship between a beneficiary, a principal caregiver, the

professional staff of a monitored in-home caregiver 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. supervision or assistance in performing activities of daily living;

2. supervision or assistance in performing instrumental activities of daily living;

3. protective supervision provided solely to assure the health and welfare of a beneficiary;

4. supervision or assistance with health related tasks, meaning any health related procedures governed under the Nurse Practice Act, in accordance with applicable laws governing the delegation of medical tasks/medication administration.

5. supervision or assistance while escorting/accompanying the individual 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. extension of therapy services to maximize independence when the caregiver has been instructed in the

performance of the activities by a licensed therapist or registered nurse.

C. Service Exclusions and Restrictions

1. Beneficiaries electing monitored in-home caregiving are not eligible to receive the following New Opportunities Waiver services during the period of time that the beneficiary is receiving monitored in-home caregiving services:

a. individual family support;

b. center-based respite;

c. supported independent living;

d. adult companion care; or

e. skilled nursing care;

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 performed in the home.

1. The agency provider must assess and approve the home in which services will be provided, and enter into contractual agreements with caregivers whom that agency has approved and trained.

2. The agency provider will pay per diem stipends to caregivers. The per diem for monitored in-home caregiving services does not include payments for room and board.

3. The agency provider must capture daily notes electronically and use the information collected to monitor beneficiary health and caregiver performance.

4. The agency provider must take such notes available to support coordinators and the state, upon request.

E. The MIHC provider must use secure, web-based information collection from principal caregivers for the purposes of monitoring beneficiary health and caregiver performance. All protected health information must be transferred, stored, and otherwise utilized in compliance with applicable federal and state privacy laws. Providers must sign, maintain on file, and comply with the LDH HIPAA business associate addendum.

F. The department shall reimburse for monitored in-home caregiving services based on a two-tiered model which is designed to address the beneficiary’s acuity. Reimbursement will not be made for room and board of the principal caregiver, and federal financial participation is not available for room and board.

G. Provider Qualifications

1. MIHC providers must be licensed according to the home and community based service provider licensing requirements contained in the R.S. 40:2120.2-2121.9 and their implementing regulations.

2. MIHC providers must enroll as a Medicaid monitored in-home caregiving provider.

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

4. The principal caregiver must:

a. be at least 18 years of age;

b. live in the home with the beneficiary; and

c. be available 24 hours a day, 7 days a week.

H. The assessment performed by the monitored in-home caregiving provider shall be reimbursed when the service has been approved by the plan of care.

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 48:

§13941. Dental Services

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

1. adult diagnostic services;

2. preventative services;

3. restorative services;

4. endodontics;

5. periodontics;

6. prosthodontics;

7. oral and maxillofacial surgery;

8. orthodontics;

9. emergency care; and

10. adjunctive general services

B. Dental Service Exclusions

1. NOW dental services are not available to children (up to 21 years of age). Children access dental services through the EPSDT benefit.

2. Non-covered services include but are not limited to the following:

a. services that are not medically necessary to the beneficiary’s dental health;

b. dental care for cosmetic reasons;

c. experimental procedures;

d. plaque control;

e. any periapical radiographic images, occlusal radiographic images, complete series, or panoramic radiographic images taken annually or routinely at the time of a dental examination for screening purposes;

f. routine post-operative services – these services are covered as part of the fee for the initial treatment provided;

g. treatment of incipient or non-carious lesions (other than covered sealants and fluoride);

h. services that are eligible for reimbursement by insurance or covered under any other insurance or medical health plan;

i. dental expenses related to any dental services:

i. started after the beneficiary's coverage ended, or

ii. received before the beneficiary became eligible for these service; and

j. administration of in-office pre-medication.

C. Providers are enrolled through the LA Dental Benefit Program, which is responsible for maintaining provider lists.

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 48:

Chapter 141. Self-Direction Initiative

§14101. Self-Direction Service Delivery Option

A. The self-direction initiative is a voluntary, self-determination option which allows the beneficiary to coordinate the delivery of NOW services, as designated by OCDD, through an

individual direct support professional rather than through a licensed, enrolled provider agency. Selection of this option requires that the beneficiary utilize a payment mechanism approved by the department to manage the required fiscal functions that are usually handled by a provider agency.

B. Beneficiary Responsibilities. Waiver beneficiaries choosing the self-directed service delivery option must understand the rights, risks and responsibilities of managing his/her own care and individual budget. If the beneficiary is unable to make decisions independently, he/she must have an authorized representative who understands the rights, risks and responsibilities of managing his/her care and supports within his/her individual budget. Responsibilities of the beneficiary or authorized representative include:

1. – 2. ...

3. 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 CPOC to meet his/her needs;

b. the beneficiary’s individual budget includes a potential amount of dollars within which the beneficiary or his/her authorized representative exercises decision-making

responsibility concerning the selection of services and service providers.

C. ...

1. Voluntary Termination. The waiver beneficiary may choose at any time to withdraw from the self-direction service delivery option and return to the traditional provider agency management of services.

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

a. the health or welfare of the beneficiary is compromised by continued participation in the self-direction service delivery option;

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

c. there is misuse of public funds by the beneficiary or the authorized representative; or

d. over three consecutive payment cycles, the beneficiary or authorized representative:

C.2.d.i. – D. ...

E. All services must be documented in service notes, which describes the services rendered and progress towards the

beneficiary’s personal outcomes and his/her comprehensive plan of care.

F. Service Limits

1. Authorized representatives, legally responsible individuals, and legal guardians may be the employers in the self-directed option but may not also be the employees.

2. Legally responsible individuals may only be paid for services when the care is extraordinary care 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.

3. Family members who are employed in the self-directed option must meet the same standards as direct support staff that are not related to the beneficiary.

4. Family members who live in the home with the beneficiary cannot exceed a total of 40 hours per week when employed in the self-directed option.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1209 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1651 (August 2007), amended by the Department of Health and

Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:79 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:58 (January 2018) LR 48:

Chapter 142. Provider Participation Requirements

§14202. Incident Reporting, Tracking and Follow-Up

A. The direct service provider is responsible for responding to, reviewing, and remediating incidents that occur to the beneficiaries they support. Direct service providers must comply with any other rules promulgated by the LDH regarding incident reporting and response.

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 44:58 (January 2018), amended LR 48:

Chapter 143. Reimbursement

§14301. Unit of Reimbursement

A. Reimbursement for services shall be a prospective flat rate for each approved unit of service provided to the beneficiary. One-quarter hour (15 minutes) is the standard unit of service and reimbursement shall not be made for less than 15

minutes (one-quarter hour) of service. This covers both service provision and administrative costs for the following services:

1. ...

2. community integration development:

a. up to three beneficiaries may choose to share community integration development if they share a common provider of this service;

2.b. – 4. ...

5. individual and family support-day and night:

a. up to three beneficiaries may choose to share individualized and family support services if they share a common provider;

5.b. – 6. ...

7. skilled nursing services:

a. up to three beneficiaries may choose to share skilled nursing services if they share a common provider;

b. – c. ...

8. supported employment;

9. – 10. ...

B. The following services are to be paid at cost, based on the need of the beneficiary and when the service has been prior authorized and on the CPOC:

1. – 3. ...

C. The following services are paid through a per diem:

1. – 2. ...

3. adult companion care;

4. individual and family support supplemental payments; and

5. monitored in-home caregiving services.

D. – F.4.a. ...

G. 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.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1209 (June 2004), amended by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 34:252 (February 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 35:1851 (September 2009), LR 36:1247 (June 2010), LR 37:2158 (July 2011), LR 39:1049 (April 2013), LR 40:80 (January 2014), LR 42:898 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR

44:58 (January 2018), LR 45:44 (January 2019), LR 46:1682 (December 2020), LR 48:41 (January 2022), LR 48:

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.

Dr. Courtney N. Phillips

Secretary

RULE

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

Home and Community-Based Services Waivers
Residential Options Waiver
Dental Services
(LAC 50:XXI.Chapters 161-169)

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:XXI.Chapters 161-169 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 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. 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. The Residential Options Waiver services are provided with the goal of promoting independence through strengthening the beneficiary's capacity for self-care, self-sufficiency and community integration utilizing a wide array of services, supports and residential options. The ROW is person-centered incorporating the beneficiary's support needs and preferences, while supporting the dignity, quality of life, and security with the goal of integrating the participant into the community.

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

§16103. Program Description

A. ...

B. The ROW offers an alternative to institutional care with the objectives to:

1. promote independence for beneficiaries through the provision of services meeting the highest standards of quality and national best practices, while ensuring health and safety through a comprehensive system of beneficiary safeguards;

2. ...

3. offer access to services which would protect the health and safety of the beneficiary.

C. ROW services are accessed through a single point of entry in the human services district or authority. All waiver beneficiaries choose their support coordination and direct service provider agencies through the freedom of choice process.

1. The plan of care (POC) shall be developed using a person-centered process coordinated by the beneficiary’s support coordinator. The initial POC is developed during this person-centered planning process and approved by the human services district or authority. Annual reassessments may be

approved by the support coordination agency supervisor as allowed by Office for Citizens with Developmental Disabilities (OCDD) policy.

D. ...

E. The total expenditures available for each waiver beneficiary is established through an assessment of individual support needs and may not exceed the approved ICF/IID Inventory for Client and Agency Planning (ICAP) rate/ROW budget level established for that individual except as approved by the OCDD assistant secretary, deputy assistant secretary, or his/her designee to prevent institutionalization. ROW acuity/budget cap level(s) are based upon each beneficiary's ICAP assessment tool results and may change as the beneficiary's needs change.

1. When the department determines that it is necessary to adjust the ICF/IID ICAP rate, each waiver beneficiary's annual service budget may be adjusted to ensure that the beneficiary's total available expenditures do not exceed the approved ICAP rate. A reassessment of the beneficiary's ICAP level will be conducted to determine the most appropriate support level.

2. The average beneficiary's expenditures for all waiver services shall not exceed the average Medicaid expenditures for ICF/IID services.

3. Beneficiaries may exceed assigned ROW acuity/budget cap level(s) to access defined additional support needs to prevent institutionalization on a case by case basis according to policy and as approved by the OCDD assistant secretary or his/her designee.

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 case management agency will conduct person centered discovery activities.

5. ...

F. No reimbursement for ROW services shall be made for a beneficiary who is admitted to an inpatient setting.

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:

§16104. Settings for Home and Community Based Services

A. ROW beneficiaries are expected to be integrated in and have full access to the greater community while receiving services, to the same extent as individuals without disabilities. Providers shall meet the requirements of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) home and community-based setting requirements for home and community-based services (HCBS) waivers as delineated in LAC 50:XXI.901 or any superseding 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, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1764 (December 2019), amended LR 47:1508 (October 2021), LR 48:

§16105. Beneficiary Qualifications

A. – A.9. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2441 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2155 (October 2015), amended by the

Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2530 (December 2017), LR 45:1764 (December 2019), LR 47:1508 (October 2021), LR 48

§16106. Money Follows the Person Rebalancing Demonstration

A. – A.1. ...

B. Individuals must meet the following criteria for participation in the MFP Rebalancing Demonstration.

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

b. ...

2. The beneficiary or his/her responsible representative must provide informed consent for both transition and participation in the demonstration.

C. – D. ...

E. MFP beneficiaries cannot participate in ROW shared living services which serve more than four persons in a single residence.

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:

§16109. Admission Denial or Discharge Criteria

A. – A.8. ...

B. Beneficiaries shall be discharged from the ROW if any of the following conditions are determined:

1. – 6. ...

7. the health and welfare of the beneficiary cannot be assured through the provision of ROW services in accordance with the beneficiary's approved POC;

8. the beneficiary fails to cooperate in the eligibility renewal process or the implementation of the approved POC, or the responsibilities of the ROW beneficiary;

9. continuity of stay for consideration of Medicaid eligibility under the special income criteria is interrupted as a result of the beneficiary not receiving ROW services during a period of 30 consecutive days;

a. continuity of stay is not considered to be interrupted if the beneficiary is admitted to a hospital, nursing facility, or ICF/IID.

b. the beneficiary shall be discharged from the ROW if the treating physician documents that the institutional stay will exceed 90 days; or

10. continuity of services is interrupted as a result of the beneficiary not receiving ROW services during a period of 30 consecutive days.

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:

Chapter 163. Covered Services

§16301. Assistive Technology and Specialized Medical Equipment and Supplies

A. Assistive technology and specialized medical equipment and supplies (AT/SMES) service includes providing specialized devices, controls, or appliances which enable a beneficiary to increase his/her ability to perform activities of daily living,

ensure safety, and/or to perceive, control, and communicate within his/her environment.

1. – 1.c. ...

d. items that will increase, maintain, or improve ability of the beneficiary to function more independently in the home and/or community; and

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.

2.a. – 3. ...

B. AT/SMES services provided through the ROW include the following services:

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. – 3. ...

4. training or technical assistance on the use and maintenance of the equipment or device for the beneficiary or,

where appropriate, his/her family members, legal guardian or responsible representative;

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

6. – 7.a. ...

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

C. Approval of AT/SMES services through ROW is contingent upon the denial of a prior authorization request for the item as a Medicaid State Plan service and demonstration of the direct medical, habilitative, or remedial benefit of the item to the beneficiary.

C.1. - D. ...

E. Service Exclusions

1. Assistive technology devices and specialized equipment and supplies that are of general utility or maintenance and items that are not of direct medical or remedial benefit to the beneficiary are excluded from coverage.

2. – 3. ...

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

1. – 2.b. ...

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.

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 47:1509 (October 2021), LR 48:

§16303. Community Living Supports

A. Community living supports (CLS) are provided to a beneficiary in his/her own home and in the community to achieve and/or to maintain the outcomes of increased independence, productivity, and enhanced family functioning, to provide relief

of the caregiver, and to provide for inclusion in the community. Community living supports may be a self-directed service.

B. Community living supports focus on the achievement of one or more goals as indicated in the beneficiary's approved plan of care by incorporating teaching and support strategies. Supports provided are related to the acquisition, improvement, and maintenance of independence, autonomy and adaptive skills. These skills include:

1. – 4. ...

C. Place of Service. CLS services are furnished to adults and children who live in a home that is leased or owned by the beneficiary or his/her family. Services may be provided in the home or community, with the place of residence as the primary setting.

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. – 5. ...

E. Service Exclusions

1. ...

2. Payment does not include room and board or the maintenance, upkeep, and improvement of the provider’s or family’s residence.

3. Community living supports may not be provided in a licensed respite care facility.

4. Community living supports services are not available to beneficiaries receiving any of the following services:

a. shared living;

b. host home; or

c. companion care.

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

a. day habitation;

b. prevocational services;

c. supported employment;

d. respite care services-out of home;

e. transportation-community access;

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

g. adult day health care.

6. – 9.d. Repealed.

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, Sunday to Saturday, for services delivered by family members living in the home.

2. Legally responsible individuals (such as a parent or spouse) and legal guardians may provide community living supports 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.

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:

§16305. Companion Care

A. Companion care services provide supports to assist the beneficiary in achieving and/or maintaining increased independence, productivity and community inclusion as identified in the beneficiary's plan of care. These services are designed for individuals who live independently and can manage their own household with limited supports. The companion provides personal care and supportive services to a beneficiary who resides as a roommate with his/her caregiver. This service includes:

1. providing assistance with all of the activities of daily living as indicated in the beneficiary's POC; and

2. ...

B. Companion care services can be arranged by licensed providers who hire companions. The beneficiary must be able to self-direct services to companion. The companion is a principal care provider who is at least 18 years of age, who lives with the beneficiary as a roommate, and provides services in the beneficiary's home. The companion is a contracted employee of the provider agency and is paid as such by the provider.

C. Provider Responsibilities

1. The provider organization shall develop a written agreement that defines all of the shared responsibilities between the companion and the beneficiary. This agreement becomes a part of the beneficiary's plan of care. The written agreement shall include, but is not limited to:

a. – c. ...

2. Revisions to this agreement must be facilitated by the provider and approved as part of the plan of care following the same process as would any revision to a plan of care. Revisions can be initiated by the beneficiary, the companion, the provider, or a member of the beneficiary's support team.

3. The provider is responsible for performing the following functions which are included in the daily rate:

a. ...

b. conducting an initial inspection of the beneficiary's home with on-going periodic inspections of a frequency determined by the provider;

c. making contact with the companion at a minimum of once per week, or more often as specified in the beneficiary's plan of care; and

d. ...

4. The provider shall facilitate a signed written agreement between the companion and the beneficiary.

D. Responsibilities of the companion include:

1. – 4. ...

5. participating in and following the beneficiary's plan of care and any support plans;

6. ...

7. being available in accordance with a pre-arranged time schedule as outlined in the beneficiary's plan of care;

8. ...

9. being available 24 hours a day (by phone contact) to the beneficiary to provide supports on short notice as a need arises.

E. – E.1. ...

F. Service Exclusions

1. - 1.e. ...

2. Companion care services are not available to beneficiaries under the age of 18.

3. Legally responsible individuals and legal guardians may provide companion care services for a relative who 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.

a. – c. Repealed.

4. Payment does not include room and board or maintenance, upkeep, and improvement of the beneficiaries or provider’s property.

F.5. - 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:

§16307. Day Habilitation Services

A. Day habilitation is services that 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. 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.

1. – 3. Repealed.

B. Day habilitation may be delivered in a combination of these three service types:

1. onsite day habilitation;

2. community life engagement; and

3. virtual day habilitation.

a. – d. Repealed.

C. Day habilitation services are provided on a regularly scheduled basis for one or more days per week in a variety of community settings that are separate from the beneficiary's private residence, with the exception of virtual day habilitation. Day habilitation services should not be limited to a fixed site facility. Activities and environments are designed to foster personal choice in developing the beneficiary's meaningful day including community activities alongside people who do not receive home and community-based services.

1. – 2. Repealed.

D. The day habilitation provider is responsible for all transportation between day habilitation sites and while providing community life engagement services in the community.

1. Transportation can only 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.

E. Beneficiaries receiving day habilitation services may also receive prevocational and/or individual supported employment services on the same day, but these services cannot be provided during the same time period or total more than five hours per day combined.

1. – 3.g. Repealed.

F. 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 plan of care.

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 and 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 by the local governing entity or the OCDD state office.

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.

G. 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.

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:

§16309. Dental Services

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

1. adult diagnostic services;

2. preventative services;

3. restorative services;

4. endodontics;

5. periodontics;

6. prosthodontics;

7. oral and maxillofacial surgery;

8. orthodontics;

9. emergency care; and

10. adjunctive general services

B. Dental Service Exclusions

1. ROW dental services are not available to children (up to 21 years of age). Children access dental services through the EPSDT benefit.

2. services must first be exhausted prior to accessing ROW dental services. Non-covered services include but are not limited to the following:

a. services that are not medically necessary to the beneficiary’s dental health;

b. dental care for cosmetic reasons;

c. experimental procedures;

d. plaque control;

e. any periapical radiographic images, occlusal radiographic images, complete series, or panoramic radiographic images taken annually or routinely at the time of a dental examination for screening purposes;

f. routine post-operative services – these services are covered as part of the fee for the initial treatment provided;

g. treatment of incipient or non-carious lesions (other than covered sealants and fluoride);

h. services that are eligible for reimbursement by insurance or covered under any other insurance or medical health plan;

i. dental expenses related to any dental services:

i. started after the beneficiary's coverage ended, or

ii. received before the beneficiary became eligible for these services; and

j. Administration of in-office pre-medication.

C. Provider Qualifications. Providers are enrolled through the LA Dental Benefit Program, which is responsible for maintaining provider lists.

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:

§16311. Environmental Accessibility Adaptations

A. Environmental accessibility adaptations are physical adaptations to the beneficiary's home or vehicle which are necessary to ensure health, welfare, and safety of the beneficiary, or which enable the beneficiary to function with greater independence, without which the beneficiary would require additional supports or institutionalization. Environmental adaptations must be specified in the beneficiary's plan of care.

1. Reimbursement shall not be paid until receipt of written documentation that the job has been completed to the satisfaction of the beneficiary.

B. Environmental adaptation services to the home and vehicle include the following:

1. ...

2. training the beneficiary and the provider in the use and maintenance of the environmental adaptation(s);

3. – 4. ...

C. Home adaptations which pertain to modifications that are made to a beneficiary’s primary residence. Such adaptations to the home may include bathroom modifications, ramps, or other adaptations to make the home accessible to the beneficiary.

1. ...

2. The service may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the beneficiary.

D. – F.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:

4.a. – 5. ...

G. Vehicle adaptations pertain to modifications to a vehicle that is the waiver beneficiary’s primary means of transportation in order to accommodate his/her special needs.

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

G.2. – H.1.b. ...

2. Vehicle modification funds may not be used for modifications which are of general utility and are not of direct medical or remedial benefit to the beneficiary.

H.3. – I.3. ...

4. 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 from manufacturers.

J. – J.4. ...

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:

§16313. Host Home

A. Host home services are personal care and supportive services provided to a beneficiary who lives in a private home with a family who is not the beneficiary's parent, legal

representative, or spouse. Host home families are a stand-alone family living arrangement in which the principle caregiver in the host home assumes the direct responsibility for the beneficiary’s physical, social, and emotional well-being and growth in a family environment. Host home services are to take into account compatibility with the host home family members, including age, support needs, and privacy needs.

B. – B.4. ...

NOTE: Natural supports are also encouraged and supported when possible. Supports are to be consistent with the beneficiary’s skill level, goals, and interests.

C. Host home provider agencies oversee and monitor the host home contractor to ensure the availability, quality, and continuity of host home services. Host home provider agencies are responsible for the following functions:

1. ...

2. making an initial inspection and periodic inspections of the host home and upon any significant changes in the host family unit or significant events which may impact the beneficiary;

3. having 24-hour responsibility over host home services to the beneficiary, which includes back-up staffing for scheduled and unscheduled absences of the host home family for

up to 360 hours (15 days) as authorized by the beneficiary’s plan of care; and

4. providing relief staffing in the beneficiary’s home or in another host home family's home.

D. Host home contractors are responsible for:

1. attending the beneficiary’s plan of care meeting and participating, including providing information needed in the development of the plan;

2. following all aspects of the beneficiary’s plan of care and any support plans;

3. maintaining the beneficiary’s documentation;

4. assisting the beneficiary in attending appointments (i.e., medical, therapy, etc.) and undergoing any specialized training deemed necessary by the provider agency, or required by the department, to provide supports in the host home setting;

5. following all requirements for staff as in any other waiver service including immediately reporting to the department and applicable authorities any major issues or concerns related to the beneficiary’s safety and well-being; and

D.6. – E. ...

1. If the beneficiary is a child, the host home family is to provide the supports required to meet the needs of a child as any family would for a minor child.

2. ...

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

F. Host home contractors serving adults are required to be available for daily supervision, support needs or emergencies as outlined in the adult beneficiary’s POC based on medical, health and behavioral needs, age, capabilities and any special needs.

1. ...

G. Host home contractors who are engaged in employment outside the home must adjust these duties to allow the flexibility needed to meet their responsibilities to the beneficiary.

H. Host Home Capacity. Regardless of the funding source, a host home contractor may not provide services for more than two beneficiaries in the home.

I. – I.3. ...

4. Payment will not be made for services provided by a relative who is a:

a. – c. ...

d. spouse of the beneficiary.

5. – 6. ...

7. Environmental adaptations are not available to beneficiaries receiving host home services since the beneficiary’s place of residence is owned or leased by the host home family.

J. – J.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 for Citizens with Developmental Disabilities, LR 33:2447 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2160 (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 47:1514 (October 2021), LR 48:

§16317. Nursing Services

A. ...

1. Nursing services must be included in the beneficiary’s plan of care and must have the following:

a. – g. ...

2. The beneficiary’s nurse must submit updates every 60 days and include any changes to the beneficiary’s needs and/or physician's orders.

B. Consultations include assessments, health related training/education for the beneficiary and the beneficiary's caregivers, and healthcare needs related to prevention and primary care activities.

1. – 2. ...

3. Health related training and education service is the only nursing procedure which can be provided to more than one beneficiary simultaneously.

C. – C.1. ...

D. Service Requirements

1. Nursing services are secondary to EPSDT services for beneficiaries under the age of 21 years. Beneficiaries under the age of 21 have access to nursing services (home health and extended care) under the Medicaid State Plan.

2. Adults have access only to home health nursing services under the Medicaid State Plan. Beneficiaries must access and exhaust all available Medicaid State Plan services prior to accessing ROW nursing services.

E. – F.4.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 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 41:2161 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1515 (October 2021), LR 48:

§16319. One Time Transitional Services

A. One-time transitional services are non-reoccurring set-up expenses to assist a beneficiary who is moving from an institutional setting to his or her own home. The beneficiary's support coordinator assists in accessing funds and making arrangements in preparation for moving into the residence.

B. – B.5. ...

C. Service Limits

1. There is a one-time, lifetime maximum services cap of $3,000 per beneficiary.

C.2. – D.1.b. ...

2. One-time transitional services are not available to beneficiaries who are receiving host home services.

3. One-time transitional services are not available to beneficiaries who are moving into a family member's home.

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 33:2449 (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:

§16321. Personal Emergency Response System (PERS)

A. Personal emergency response system (PERS) service is an electronic device connected to the beneficiary's phone that enables him or her to secure help in an emergency. The service also includes an option in which the beneficiary would wear a portable help button. The device is programmed to emit a signal to the PERS response center where trained professionals respond to the beneficiary's emergency situation.

B. Beneficiary Qualifications. PERS service is most appropriate for beneficiaries who:

1. – 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.

D. Service Exclusions

1. ...

2. PERS services are not available to beneficiaries who receive 24-hour direct care supports.

E. Provider Qualifications

1. – 2. ...

3. Providers must meet manufacturer's specifications, response requirements, maintenance records, and enrollee education.

4. ...

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 33:2249 (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 47:1516 (October 2021), LR 48:

§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 may be delivered in a combination of these three service types:

1. onsite prevocational services;

2. community career planning; and

3. virtual prevocational services.

4. – 4.c. Repealed.

C. Prevocational services are to be provided in a variety of locations in the community and are not to be limited to a fixed site facility. Activities associated with prevocational services should focus on preparing the beneficiary for integrated individual employment in the community. These services are operated through a provider agency that is licensed by the appropriate state licensing agency.

1. – 2. Repealed.

D. Beneficiaries receiving prevocational services must participate in activities designed to establish an employment goal. Prevocational services are designed to help create a path

to integrated community-based employment for which a beneficiary is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Prevocational services may include assistance with personal care or with activities of daily living.

1. – 3. Repealed.

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.

a. – b. ...

2. Prevocational services are not available to individuals who are eligible to participate in programs funded under section 110 of the Rehabilitation Act of 1973 or sections 602(16) and (17) of the Individuals with Disabilities Education

Act [20 U.S.C. 1401(26) and (29)] as amended, and those covered under the state plan, if applicable.

3. Prevocational services cannot be billed for at the same time on the same day as other ROW services.

a. – g. ...

4. Prevocational services may otherwise be billed at the same time on the same day as professional services when there are direct contacts needed in the development of a support plan.

a. – c. Repealed.

5. Transportation is only provided on the day that a prevocational service is provided. Transportation is part of the service except for virtual prevocational services.

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

b. During travel training, providers must not also bill for the transportation component as this is included in the rate for the number of service hours provided.

c. Transportation-community access services shall not be used for transportation to or from any prevocational services.

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 or total more than five hours per day combined.

2. All virtual prevocational services must be approved by the local governing entity or the OCDD state office.

3. 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 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:

§16325. Professional Services

A. Professional services are direct services to beneficiaries based on the beneficiary's need, which assist the beneficiary, unpaid caregivers, and/or paid caregivers in carrying out the beneficiary's approved plan and which are necessary to improve the beneficiary's independence and inclusion in his/her community. The beneficiary must be present in order for the professional to bill for services. Professional services include nutritional services, speech therapy, occupational therapy, physical therapy, social work, and psychological services. All services are to be included in the beneficiary's plan of care. The specific service provided to a beneficiary must be within the professional's area of specialty and licensing.

B. – B.6 ...

C. Professional services can include:

1. ...

2. providing training to the beneficiary, family, and caregivers with the goal of increased skill acquisition and proficiency;

3. – 4. ...

5. providing information to the beneficiary, family, and caregivers, along with other support team members, to assist in planning, developing, and implementing a beneficiary's plan of care;

6. – 7.a. ...

8. providing therapy to the beneficiary necessary to the development of critical skills; and

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

***

D. Service Exclusions

1. Private insurance must be billed and exhausted prior to accessing waiver funds. Professional services may only be furnished and reimbursed through ROW when the services are medically necessary, or have habilitative or remedial benefit to the beneficiary.

D.2. – E.4.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 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 41:2163 (October 2015), by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, amended LR 47:1518 (October 2021), LR 48:

§16327. Respite Care Services–Out of Home

A. Respite care services–out of home are provided on a short-term basis to beneficiaries who are unable to care for themselves due to the absence of, or need for, relief of caregivers who normally provide care and support. Services are provided by a center-based respite provider.

1. A licensed respite care facility shall insure that community activities are available to the beneficiary in accordance with his approved POC, including transportation to and from these activities.

2. While receiving respite care services, the beneficiary’s routine is maintained in order to attend school, school activities or other community activities. Community activities and transportation to and from these activities in which the beneficiary typically engages in are to be available while receiving respite services-out of home.

a. These activities should be included in the beneficiary’s approved plan of care. This will provide the

beneficiary the opportunity to continue to participate in typical routine activities.

b. ...

B. Service Limits

1. Respite care services are limited to 720 hours per beneficiary, per POC year.

2. – 3. ...

C. Service Exclusions

1. ...

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

C.2.a. – 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:

§16329. Shared Living Services

A. Shared living services are provided to a beneficiary in his/her home and community to achieve, improve, and/or maintain social and adaptive skills necessary to enable the beneficiary to reside in the community and to participate as independently as possible. Services are chosen by the beneficiary and developed in accordance with his/her goals and wishes with regard to compatibility, interests, age and privacy in the shared living setting.

1. A shared living services provider delivers supports which include:

a. ...

b. assistance with activities of daily living included in the beneficiary's POC;

c. – f. ...

g. other responsibilities as required in each beneficiary's POC.

2. Shared living services focus on the beneficiary's preferences and goals.

3. Supports provided are related to the acquisition, improvement, and maintenance in level of independence, autonomy, and adaptive skills and are to be included in each beneficiary's plan of care. This includes:

a. – c. ...

4. The overall goal is to provide the beneficiary the ability to successfully reside with others in the community while sharing supports.

5. Shared living services take into account the compatibility of the beneficiaries sharing services, which includes individual interests, age of the beneficiaries, and the privacy needs of each beneficiary.

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

6. The shared living setting is selected by each beneficiary among all available alternatives and is identified in each beneficiary’s plan of care.

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. Shared living services may be shared by up to four beneficiaries who have a common shared living provider agency.

8. Shared living services must be agreed to by each beneficiary and the health and welfare must be able to be assured for each beneficiary.

a. ...

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

9. The shared living service setting is integrated in, and facilitates each beneficiary’s full access to, the greater community, which includes providing beneficiaries with the same opportunities as individuals without disabilities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community.

B. – B.3. ...

4. All shared living service beneficiaries are required to have an individualized back-up staffing plan and an individualized emergency evacuation plan which are to be submitted with their plan of care.

5. – 6. ...

7. Shared living service providers are responsible for providing 24-hour staff availability along with other identified responsibilities as indicated in each beneficiary’s individualized plan of care. This includes responsibility for

each beneficiary’s routine daily schedule, for ensuring the health and welfare of each beneficiary while in his or her place of residence and in the community, and for any other waiver services provided by the shared living services provider.

8. Shared living services may be provided in a residence that is owned or leased by the provider or that is owned or leased by the beneficiary. Services may not be provided in a residence that is owned or leased by any legally responsible relative of the beneficiary. If shared living services are provided in a residence that is owned or leased by the provider, any modification of the conditions must be supported by specific assessed needs and documented in the beneficiary’s plan of care. The provider is responsible for the cost of, and implementation of, the modification when the residence is owned or leased by the provider.

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

a. the unit or room is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the beneficiary receiving services, and the beneficiary has, at a minimum, the same responsibilities and protections from eviction that the tenants have under the

landlord/tenant laws of the state, parish, city, or other designated entity;

b. each beneficiary has privacy in their sleeping or living unit, which requires the following:

i. ...

ii. beneficiaries share units only at the beneficiary’s choice; and

iii. beneficiaries have the freedom to furnish and decorate their sleeping or living units;

c. beneficiaries have the freedom and support to control their own schedules and activities, and have access to food at any time;

d. beneficiaries are able to have visitors of their choosing at any time; and

e. the setting is physically accessible to the beneficiary.

C. Shared Living Options

1. ...

a. The number of beneficiaries for the shared living conversion option shall not exceed the licensed and Medicaid-funded bed capacity of the ICF/IID on October 1, 2009, or up to six individuals, whichever is less.

b. The ICF/IID used for the shared living conversion option must meet the department’s operational,

programming and quality assurances of health and safety for all beneficiaries.

c. The provider of shared living services is responsible for the overall assurances of health and safety for all beneficiaries.

d. The provider of shared living conversion option may provide nursing services and professional services to beneficiaries utilizing this residential services option.

2. – 2.a. ...

b. The shared living waiver home must be either a home owned or leased by the waiver beneficiaries or a home owned or leased and operated by a licensed shared living provider.

c. ...

d. The shared living provider is responsible for the overall assurances of health and safety for all beneficiaries.

3. ICF/IID providers who convert an ICF/IID to a shared living home via the shared living conversion model must be approved by OCDD and licensed by HSS prior to providing services in this setting, and prior to accepting any ROW beneficiary or applicant for residential or any other developmental disability service(s).

4. – 5. ...

D. Service Exclusions and Limitations

1. Payment does not include room and board or maintenance, upkeep or improvements of the beneficiary's or the provider's property.

2. ...

3. Beneficiaries may receive one-time transitional services only if the beneficiary owns or leases the home and the service provider is not the owner or landlord of the home.

4. MFP beneficiaries cannot participate in ROW shared living services which serve more than four persons in a single residence.

5. Transportation-community access services cannot be billed or provided for beneficiaries receiving shared living services, as this is a component of shared living services.

6. The following services are not available to beneficiaries receiving shared living services:

a. – g. ...

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

8. – 9 ...

10. Payment will not be made for services provided by a relative who is a:

a. – c. ...

d. spouse of the beneficiary.

11. The shared living staff may not live in the beneficiary’s place of residence.

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:

§16333. Support Coordination

A. Support coordination services are provided to all beneficiaries to provide assistance in gaining access to needed waiver services and Medicaid State Plan services, as well as needed medical, social, education, and other services, regardless of the funding source for the services. Support coordination services include assistance with the selection of service providers, development/revision of the plan of care, and monitoring of services.

1. Support coordinators shall be responsible for ongoing monitoring of the provision of services included in the beneficiary's approved POC.

2. Support coordinators shall also participate in the evaluation and re-evaluation of the beneficiary's POC.

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

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

C. Service Limits

1. Support coordination shall not exceed 12 units. A calendar month is a unit. Virtual visits are permitted; however, the initial and annual plan of care meeting and at least one other meeting per year must be conducted face-to-face. When a relative living in the home or a legally responsible individual or legal guardian provides a paid ROW service, all support coordination visits must be conducted face-to-face, with no option for virtual visits.

C.2. – 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:

§16335. Supported Employment

A. Supported employment services consist of intensive, ongoing supports and services necessary for a beneficiary to achieve the desired outcome of employment in a community setting where a majority of the persons employed are without disabilities. Beneficiaries utilizing these services may need long-term supports for the life of their employment due to the nature of their disability, and natural supports may not meet this need.

1. – 2. Repealed.

B. Supported employment services provide supports in the following areas:

1. individual job placement, group employment, or self-employment;

2. job assessment, discovery, and development; and

a. – d. Repealed.

3. initial job support and job retention.

4. Repealed.

C. When supported employment services are provided at a work site where a majority of the persons employed are without disabilities, payment is made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, but payment will not be made for the supervisory activities rendered as a normal part of the business setting.

D. The provider is responsible for all transportation to all work sites related to the provision of services in group employment. Transportation to and from the service site is offered and billable as a component of the supported employment service.

1. ...

2. Time spent in transportation to and from the program shall not be included in the total number of supported employment services hours provided per day.

E. These services are also available to those beneficiaries who are self-employed. Funds for self-employment may not be used to defray any expenses associated with setting up or operating a business.

F. – F.2. ...

G. Service Limits. Beneficiaries may receive more than one type of vocational or habilitation service per day as long

as the billing criteria is followed and as long as the requirements for the minimum time spent on site are adhered to. The required minimum number of service hours per day, per beneficiary are as follows:

1. Individual supported employment services - one hour (four units). One-on-one services shall be billed in quarterly 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 - one hour (four units). One-on-one services shall be billed in quarterly 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 quarterly hour units of service up to eight hours per day and shall be based on the person centered plan and the beneficiary’s ROW budget.

4. Individual job follow-along services may be delivered virtually.

H. Service Exclusions and Restrictions. Beneficiaries receiving individual supported employment services may also receive prevocational, day habilitation, or group supported employment services. However, these services cannot be provided during the same service hours on the same day.

1. ...

2. Supportive employment cannot be billed for the same time as any other ROW services.

a. –e. Repealed.

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

4. ...

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

b. ...

5. All virtual supported employment services must be approved by the local governing entity or the OCDD state office.

a. – c. Repealed.

6. Supported employment services are not available to individuals who are eligible to participate in services that are available from programs funded under section 110 of the Rehabilitation Act of 1973 or sections 602(16) or (17) of the Individuals with Disabilities Education Act [20 U.S.C. 1401 (26) and (29)] and those covered under the state plan, if applicable.

7. – 8. Repealed.

I. Provider Qualifications. The provider must possess a valid certificate of compliance as a community rehabilitation provider (CRP) from an approved program or the certification and training as required.

1. – 2. 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 33:2453 (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:

§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 developmental 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 employees benefits as outlined in the beneficiary's POC.

1. Transportation-community access services are to be included in the beneficiary's plan of care.

2. The beneficiary must be present for the service to be billed.

3. Prior to accessing transportation-community access services, the beneficiary is to utilize free transportation provided by family, friends, and community agencies.

4. When appropriate, the beneficiary should access public transportation or the most cost-effective method of transportation prior to accessing transportation-community access services.

B. – C.1.c. ...

2. Transportation-community access services are not available to beneficiaries receiving the following services:

a. – c. ...

3. Transportation-community access will not be used to transport beneficiaries to day habilitation, pre-vocational, or supported employment services.

4. ...

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

1. – 3.a. ...

4. NEMT (family and friends transportation) providers may provide for up to three identified waiver beneficiaries.

E. Vehicle Requirements. All vehicles utilized by for profit and non-profit transportation services providers for transporting waiver beneficiaries must comply with all of the applicable state laws and regulations and are subject to inspection by the department or its designee.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2454 (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:

§16339. Housing Stabilization Transition Services

A. Housing stabilization transition services enable beneficiaries who are transitioning into a permanent supportive housing unit, including those transitioning from institutions, to secure their own housing. This service is provided while the beneficiary is in an institution and preparing to exit the institution using the waiver. The service includes the following components:

1. conducting a housing assessment to identify the beneficiary's preferences related to housing (i.e., type, location, living alone or with someone else, accommodations needed, and other important preferences), and his/her needs for support to maintain housing, including:

a. – h. ...

2. assisting a beneficiary to view and secure housing, as needed. This may include the following:

a. – e. ...

3. developing an individualized housing support plan, based upon the housing assessment, that:

a. ...

b. establishes the beneficiary's approach to meeting the goal; and

3.c. – 5. ...

B. This service is only available to beneficiaries upon referral from the support coordinator, and is not duplicative of other waiver services, including support coordination.

1. beneficiaries must be residing in a state of Louisiana permanent supportive housing unit; or

2. beneficiaries must be linked for the state of Louisiana permanent supportive housing selection process.

C. Beneficiaries are limited to receiving no more than 165 combined units of this service and the housing stabilization transition service. This limit on combined units can only be exceeded with written approval from OCDD.

D. – D.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, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2169 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1523 (October 2021), LR 48:

§16341. Housing Stabilization Services

A. Housing stabilization services enable waiver beneficiaries to maintain their own housing as set forth in the

approved plan of care. Services must be provided in the home or a community setting. Housing stabilization services include the following components:

1. conducting a housing assessment identifying the beneficiary’s preferences related to housing (type, location, living alone or with someone else, accommodations needed, and other important preferences), and needs for support to maintain housing, including:

a. – h. ...

2. assisting a beneficiary to view and secure housing, as needed and may include the following:

a. – e. ...

3. developing an individualized housing stabilization service provider plan, based upon the housing assessment, that:

a. ...

b. establishes the beneficiary’s approach to meeting the goal; and

3.c. -. 5. ...

6. providing ongoing communication with the landlord or property manager regarding:

a. the beneficiary’s disability;

b. – c. ...

7. if at any time the beneficiary's housing is placed at risk (i.e., eviction, loss of roommate or income), housing stabilization services will provide supports to retain housing or locate and secure housing to continue community-based supports, including locating new housing, sources of income, etc.

B. ...

1. beneficiaries must be residing in a state of Louisiana permanent supportive housing unit; or

2. beneficiaries must be linked for the state of Louisiana permanent supportive housing selection process.

C. Beneficiaries are limited to receiving no more than 165 combined units of this service and the housing stabilization transition service. This limit on combined units can only be exceeded with written approval from OCDD.

D. – D.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, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2170 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1524 (October 2021), LR 48:

§16343. Adult Day Health Care Services

A. Adult day health care (ADHC) services shall be furnished as specified in the POC and at an ADHC facility in a non-institutional, community-based setting encompassing both health/medical, and social services needed to ensure the optimal functioning of the beneficiary.

B. ADHC services include those core service requirements identified in the ADHC licensing standards (LAC 48:I.4243), in addition to the following:

1. ...

2. transportation between the beneficiary's place of residence and the ADHC (if the beneficiary is accompanied by the ADHC staff) in accordance with licensing standards;

3. – 9. ...

C. The number of people included in the service per day depends on the licensed capacity and attendance at each facility. The average capacity per facility is 49 beneficiaries.

D. Nurses shall be involved in the beneficiary's service delivery as specified in the plan of care (POC) or as needed. Each beneficiary has a plan of care from which the ADHC shall develop an individualized service plan based on the beneficiary's POC. If the individualized service plan calls for certain health and nursing services, the nurse on staff shall

ensure that the services are delivered while the beneficiary is at the ADHC facility.

E. - G.4. ...

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:

§16345. Monitored In-Home Caregiving Services

A. Monitored in-home caregiving (MIHC) services are provided to a beneficiary living in a private home with a principal caregiver. The principal caregiver shall be contracted by the licensed HCBS provider having a MIHC service module. The principal caregiver shall reside with the beneficiary. Professional staff employed by the HCBS provider shall provide oversight, support and monitoring of the principal caregiver, service delivery, and beneficiary outcomes through on-site visits, training, and daily web-based electronic information exchange.

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 caregiver agency provider, and the beneficiary 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. – 2. ...

3. protective supervision provided solely to assure the health and welfare of a beneficiary;

4. – 6. ...

C. Service Exclusions and Restrictions

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

a. – c. ...

d. shared living supports; and

e. adult day health care services.

f. Repealed.

D. – D.2. ...

3. The agency provider must capture daily notes electronically and use the information collected to monitor beneficiary health and caregiver performance.

4. ...

E. The MIHC provider must use secure, web-based information collection from principal caregivers for the purposes of monitoring beneficiary health and caregiver performance. All protected health information must be transferred, stored, and otherwise utilized in compliance with applicable federal and state privacy laws. Providers must sign, maintain on file, and comply with the LDH HIPAA business associate addendum.

F. The department shall reimburse for monitored in-home caregiving services based on a two-tiered model which is designed to address the beneficiary's acuity.

G. – G.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:

Chapter 165. Self-Direction Initiative

§16501. Self-Direction Service Option

A. Self-direction is a service delivery option which allows beneficiaries (or their authorized representative) to exercise employer authority in the delivery of their authorized self-directed services (community living supports).

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 contracted 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. the development of the beneficiary's plan of care;

b. organizing the unique resources the beneficiary needs;

c. training beneficiaries on their employer responsibilities;

d. – g. ...

h. ensuring beneficiary's needs are being met through services.

B. Beneficiary Eligibility. Selection of the self-direction option is strictly voluntary. To be eligible to participate in the self-direction service option, waiver beneficiaries must:

1. – 3. ...

NOTE: If the waiver beneficiary is unable to make decisions independently, the beneficiary must have a willing decision maker (an authorized representative as listed on the beneficiary's plan of care) who understands the rights, risks, and responsibilities of managing the care and supports of the beneficiary within the plan of care.

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

1. Beneficiaries must adhere to the health and welfare safeguards identified by the support team, including the following:

a. ...

b. compliance with the requirement that employees under this option must have criminal background checks prior to working with waiver beneficiaries.

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 needs.

b. The beneficiary’s individual budget includes a potential amount of dollars within which the beneficiary, or his/her authorized representative, exercises decision-making responsibility concerning the selection of services and service providers.

3. Beneficiaries are informed of the self-direction option at the time of the initial assessment, annually, or as requested by beneficiaries or their authorized representative. If the beneficiary is interested, the support coordinator will provide more information on the principles of self-determination, the services that can be self-directed, the roles and responsibilities of each service option, the benefits and risks of each service option, and the process for enrolling in self-direction.

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

4.a. – 5. ...

6. Beneficiaries who choose self-direction verify that they have received the required training by signing the service agreement form.

7. Authorized representatives may be the employer in the self-directed option but may not also be the employee.

D. ...

1. Voluntary Termination. The waiver beneficiary may choose at any time to withdraw from the self-direction service option and return to the traditional provider agency management of services.

a. ...

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.

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. the beneficiary does not receive self-directed services for 90 days or more;

b. the health, safety, or welfare of the beneficiary is compromised by continued participation in the self-direction service option;

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

d. there is misuse of public funds by the beneficiary or the authorized representative;

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 participant’s program;

ii. – v. ...

f. the beneficiary or the authorized representative consistently violates Medicaid program rules or guidelines of the self-direction option.

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. – 1.c. ...

F. Relief coverage for scheduled or unscheduled absences, which are not classified as respite care services, can be covered by other participant-directed providers and the terms can be part of the agreement between the beneficiary and the primary companion care provider.

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:

Chapter 167. Provider Participation

§16701. General Provisions

A. – B. ...

C. In order for a provider to bill for services, the waiver beneficiary and the direct service worker or professional services practitioner rendering service must be present at the time the service is rendered.

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

a. – c. ...

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

3. – 4. Repealed.

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).

§16703. Staffing Restrictions and Requirements

A. Legally responsible individuals may only be paid for services when 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.

1. – 4. Repealed.

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. Relatives must also comply with the following requirements:

a. become an employee of the beneficiary's agency of choice and meet the same standards as direct support staff who are not related to the individual;

b. ...

c. if the self-direction option is selected, relatives must:

i. become an employee of the self-direction beneficiary; and

1.c.ii. - 2.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 41:2168 (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:

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. ...

a. up to three beneficiaries may share CLS services if they share a common provider of this service;

4.b. – 9. ...

***

B. The following services are reimbursed at the cost of adaptation device, equipment or supply item:

1. ...

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.

B.2. – G. ...

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

I. – J. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office 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:

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.

Dr. Courtney N. Phillips

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
Dental Services
(LAC 50:XXI.Chapters 53-61)

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:XXI.Chapters 53-61 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 53. General Provisions

§5301. Purpose

A. The mission of this waiver is to create options and provide meaningful opportunities that enhance the lives of men and women with developmental disabilities through vocational and community inclusion. The goals of the supports waiver are as follows:

1. promote independence for beneficiaries with a developmental disability who are aged 18 years or older while ensuring health and safety through a system of beneficiary safeguards;

2. – 3. ...

B. Allocation of Waiver Opportunities. The Office for Citizens with Developmental Disabilities (OCDD) maintains the intellectual/developmental disabilities request for services registry, hereafter referred to as “the registry,” which identifies persons with intellectual and/or developmental disabilities who are found eligible for developmental disabilities services using standardized tools, and who request waiver services.

1. Services are accessed through a single point of entry in the local governing entity (LGE). When criteria are met, individuals’ names are placed on the registry and a screening of urgency of need (SUN) is completed.

2. Individuals determined to have current unmet needs as defined as a SUN score of urgent [three] or emergent [four] are offered a waiver opportunity.

3. The registry is arranged by the urgency of need and date of application for developmentally disabled (DD) waiver services.

a. – b. Repealed.

4. OCDD waiver opportunities shall be offered based on the following priority groups:

a. Individuals living at publicly operated intermediate care facilities for the developmentally disabled (ICF/DDs) or who lived at a publically operated ICF/DD when it was transitioned to a private ICF/DD through a cooperative endeavor agreement (CEA facility), or their alternates. Alternates are defined as individuals living in a private ICF/DD who will give up the private ICF/DD bed to an individual living at a publicly operated ICF/DD or to an individual who was living in a publicly operated ICF/DD when it was transitioned to a private ICF/DD through a cooperative endeavor agreement. Individuals requesting to transition from a publicly operated ICF/DD 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.

b. Individuals on the registry who have a current unmet need as defined by a SUN score of urgent [three] or emergent [four] and the earliest registry date shall be notified in writing when a funded OCDD waiver opportunity is available and a waiver offer is available.

C. – D. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1604 (September 2006), amended LR 40:2583 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2531 (December 2017), LR 48:

§5303. Settings for Home and Community-Based Services

A. Supports Waiver beneficiaries are expected to be integrated in and have full access to the greater community while receiving services, to the same extent as individuals without disabilities. Providers shall meet the requirements of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' (CMS) home and community-based setting requirements for home and community-based services (HCBS) waivers as delineated in LAC 50:XXI.901.

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 48:

Chapter 55. Target Population

§5501. Participant Qualifications and Admissions Criteria

A. In order to qualify for the supports waiver, a beneficiary must be 18 years of age or older, offered a waiver opportunity (slot), and meet all of the following criteria:

1. ...

2. be on the registry, unless otherwise specified through programmatic allocation in §5501;

3. – 4. ...

5. have assurance that the health and welfare of the beneficiary can be maintained in the community with the provision of supports waiver services;

6. have justification, as documentation in the approved plan of care, that supports waiver services are appropriate, cost effective and represent the least restrictive environment for the beneficiary;

7. - 8. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1604 (September 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:2583 (December 2014), amended

by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2532 (December 2017), LR 48:

§5503. Denial of Admission or Discharge Criteria

A. Beneficiaries shall be denied admission to, or discharged from, the supports waiver if one of the following criteria is met:

1. the beneficiary does not meet the financial eligibility requirements for the Medicaid Program;

2. the beneficiary does not meet the requirement for an ICF/DD level of care;

3. the beneficiary is incarcerated or placed under the jurisdiction of penal authorities, courts or state juvenile authorities;

4. the beneficiary resides in another state or has a change of residence to another state;

5. the beneficiary is admitted to an ICF/DD facility or nursing facility with the intent to stay and not to return to waiver services:

a. the waiver beneficiary may return to waiver services when documentation is received from the treating physician that the admission is temporary and shall not exceed 90 days;

b. the beneficiary will be discharged from the waiver on the ninety-first day if the participant is still in the ICF/DD or nursing facility;

6. the health and welfare of the beneficiary cannot be assured through the provision of supports waiver services within the beneficiary’s approved plan of care;

7. the beneficiary fails to cooperate in the eligibility determination/re-determination process and in the development or implementation of the approved plan of care; and/or

8. continuity of services is interrupted as a result of the beneficiary not receiving a supports waiver service during a period of 30 or more consecutive days. This does not include interruptions in supports waiver services because of hospitalization, institutionalization (such as ICFs/DD or nursing facilities), or non-routine lapses in services where the family agrees to provide all needed or paid natural supports. There must be documentation from the treating physician that this interruption will not exceed 90 days. During this 90-day period, the OCDD will not authorize payment for supports waiver services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:2584 (December 2014),amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:

§5505. Needs-Based Assessment

A. The Office for Citizens with Developmental Disabilities (OCDD) has developed a framework for all activities related to planning for individualized supports and services. Discovery activities include:

1. a review of the beneficiary’s records relevant to service planning (i.e., school, vocational, medical, and psychological records);

2. completing person-centered tools and worksheets, which may include a personal outcomes assessment, which assists the planning team in determining what is important to the beneficiary and his/her satisfaction or dissatisfaction with different life domain areas;

3. completion and review of the needs-based assessment within 30 days of a person being linked to a waiver opportunity and support coordination agency; and

4. review and/or completion of any additional interviews, observations, or other needed professional

assessments (i.e., occupational therapist, physical therapist, or speech therapist assessments).

B. A needs-based assessment is completed within the discovery process for all applicants aged 21 years and over who have received an OCDD waiver offer in order to identify the individual's service needs. The needs-based assessment instrument(s) is designed to evaluate the practical support requirements of individuals with developmental disabilities in daily living, medical areas, and behavioral areas as well as to identify living arrangements, existing relationships, and preferences and the levels of satisfaction in various life areas.

B.1. – C.4.e. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2532 (December 2017), LR 48:

Chapter 57. Covered Services

§5701. Supported Employment Services

A. Supported employment services consists of intensive, ongoing supports and services necessary for a beneficiary to achieve the desired outcome of employment in a community setting

where a majority of the persons employed are without disabilities. Beneficiaries utilizing these services may need long-term supports for the life of their employment due the nature of their disability, and natural supports may not meet this need.

B. Supported employment services provide supports in the following areas:

1. – 2. ...

3. initial job support and job retention, which may include assistance in personal care with activities of daily living in the supported employment setting and follow-along.

C. When supported employment services are provided at a work site where a majority of the persons employed are without disabilities, payment is only made for the adaptations, supervision and training required by beneficiaries receiving the service as a result of their disabilities. It does not include payment for the supervisory activities rendered as a normal part of the business setting.

D. ...

E. These services are also available to those beneficiaries who are self-employed. Funds for self-employment may not be used to defray any expenses associated with setting up or operating a business.

F. Supported employment services may be furnished by a coworker or other job-site personnel under the following circumstances:

1. ...

2. these beneficiaries meet the pertinent qualifications for the providers of service.

G. Service Limitations

1. - 2 ...

3. Services for individual initial job support, job retention and follow-along shall not exceed 960 units of service in a plan of care year. Individual job follow-along services may be delivered virtually.

4. ...

H. Restrictions

1. Beneficiaries receiving individual supported employment services may also receive prevocational or day habilitation services. However, these services cannot be provided during the same service hours and cannot total more than five hours of services in the same day. Beneficiaries receiving group supported employment services may also receive prevocational or day habilitation services; however, these services cannot be provided in the same service day.

2. All virtual supported employment services must be approved by the LGE or the OCDD state office.

I. Choice of this service and staff ratio needed to support the beneficiary must be documented on the plan of care.

J. Supported employment services are not available to individuals who are eligible to participate in services that are available from programs funded under section 110 of the Rehabilitation Act of 1973 or sections 602 (16) or (17) of the Individuals with Disabilities Education Act [20 U.S.C. 1401 (26 and 29)], as amended, and those covered under the state plan, if applicable.

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:

§5703. Day Habilitation

A. Day habilitation is services that 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 may be coordinated with any physical, occupational, or speech therapies identified in the individualized plan of care. Volunteer activities may be a part of this service and should follow the state guidelines for volunteering.

B. Day habilitation may be delivered in a combination of these three service types:

1. onsite day habilitation;

2. community life engagement; and

3. virtual day habilitation.

C. Day habilitation services are provided on a regularly scheduled basis for one or more days per week in a variety of community settings that are separate from the beneficiary’s private residence, with the exception of virtual day habilitation. Day habilitation services should not be limited to a fixed site facility. Activities and environments are designed to foster personal choice in developing the beneficiary’s meaningful day, including community activities alongside people who do not receive HCBS.

D. Day habilitation services may include assistance in personal care with activities of daily living.

E. All transportation costs are included in the reimbursement for day habilitation services. The beneficiary must be present to receive this service. If a beneficiary needs transportation, the provider must physically provide, arrange for, or pay for appropriate transport to and from a central location that is convenient for the beneficiary and agreed upon by the team. The beneficiary's transportation needs and this central location shall be documented in the plan of care.

F. Service Limitations. Services shall not exceed 4,800 units of service in a plan of care year.

G. Restrictions

1. Beneficiaries receiving day habilitation services may also receive prevocational or individual supported employment services, but these services cannot be provided during the same time of the day and cannot total more than five hours combined. Group supported employment services cannot be provided on the same day but can be utilized on a different service day.

2. All virtual day habilitation services must be approved by the LGE or the OCDD state office.

H. Choice of service, which includes the staff ratio, must be documented on the plan of care.

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 Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:

§5705. Prevocational Services

A. Prevocational services are individualized, person centered services that assist the 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. Career planning must be a major component of prevocational services and should include activities focused on beneficiaries becoming employed to their highest ability.

B. Prevocational services may be delivered in a combination of these three service types:

1. onsite prevocational;

2. community career planning; and

3. virtual prevocational.

C. Prevocational services are to be provided in a variety of locations in the community and are not to be limited to a fixed site facility. Activities associated with prevocational services should focus on preparing the beneficiary for integrated individual employment in the community. These services are operated through a provider agency that is licensed by the appropriate state licensing agency. Services are furnished on a regularly scheduled basis for one or more days per week.

D. Beneficiaries receiving prevocational services must participate in activities designed to establish an employment goal. Prevocational services are designed to help create a path to integrated community-based employment for which a beneficiary is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

E. Prevocational services may include assistance in personal care with activities of daily living. Choice of this service and staff ratio needed to support the beneficiary must be documented on the plan of care.

F. All transportation costs are included in the reimbursement for prevocational services. The beneficiary must be present to receive this service. If a beneficiary needs transportation, the provider must physically provide, arrange, or pay for appropriate transport to and from a central location that is convenient for the beneficiary and agreed upon by the team. The beneficiary's transportation needs and this central location shall be documented in the plan of care.

G. Service Limitations. Services shall not exceed 4,800 units of service in a plan of care year.

H. Restrictions

1. Beneficiaries receiving prevocational services may also receive day habilitation or individualized supported employment services, but these services cannot be provided during the same time of the day and cannot total more than five hours combined in the same service day. Group supported employment services cannot be provided on the same day but can be utilized on a different service day.

2. All virtual prevocational services must be approved by the LGE or the OCDD state office.

I. Prevocational services are not available to individuals who are eligible to participate in programs funded under section 110 of the Rehabilitation Act of 1973 or sections 602 (16) or (17) of the Individuals with Disabilities Education

Act [20 U.S.C. 1401 (26 and 29)], as amended, and those covered under the state plan, if applicable.

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 48:

§5707. Respite

A. Respite care is a service provided on a short-term basis to a beneficiary who is unable to care for himself/herself because of the absence or need for relief of those unpaid persons normally providing care for the beneficiary.

B. Respite may be provided in a licensed respite care facility determined appropriate by the beneficiary, responsible party, in the beneficiary’s home or private place of residence.

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 of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1606 (September 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:2586 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:

§5709. Habilitation

A. Habilitation offers services designed to assist the beneficiary in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community settings.

B. Habilitation is provided in the home or community, includes necessary transportation and included on the plan of care as determined appropriate.

C. Habilitation services may include, but are not limited to:

1. ...

2. travel training activities in the community that promote community independence, to include but not limited to, place of individual employment, church or other community

activity. This does not include group supported employment, day habilitation, or prevocational sites.

D. – E. ...

F. Beneficiaries receiving habilitation may use this service in conjunction with other supports waiver services, as long as other services are not provided during the same period in a day.

NOTE: Beneficiaries who are age 18 through 21 may receive these services as outlined on their plan of care through the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program, if applicable.

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 32:1606 (September 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:2586 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:

§5713. Personal Emergency Response System

A. A personal emergency response system (PERS) is an electronic device connected to the beneficiary’s phone which enables a beneficiary to secure help in the community. The system is programmed to signal a response center staffed by trained professionals once a "help" button is activated.

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, Office for Citizens with Developmental Disabilities, LR 32:1607 (September 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:2587 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:

§5715. Support Coordination

A. Support coordination is a service that will assist beneficiaries in gaining access to all of their necessary services, as well as medical, social, educational and other services, regardless of the funding source for the services. Support coordinators shall be responsible for on-going

monitoring of the provision of services included in the beneficiary’s approved plan of care.

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 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 48:

§5717. Housing Stabilization Transition Services

A. Housing stabilization transition services enable beneficiaries who are transitioning into a permanent supportive housing unit, including those transitioning from institutions, to secure their own housing. The service is provided while the beneficiary is in an institution and preparing to exit the institution using the waiver. The service includes the following components:

1. conducting a housing assessment to identify the beneficiary’s preferences related to housing (i.e., type, location, living alone or with someone else, accommodations

needed, and other important preferences), and his/her needs for support to maintain housing, including:

a. – h. ...

2. assisting the beneficiary to view and secure housing as needed, which may include arranging and providing transportation;

3. assisting the beneficiary to secure supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings;

4. developing an individualized housing support plan based upon the housing assessment that:

a. ...

b. establishes the beneficiary's approach to meeting the goal; and

A.4.c. – B. ...

C. Beneficiaries may not exceed 165 combined units of this service and the housing stabilization service.

1. ...

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 40:81 (January 2014) amended by the Department of Health, Bureau of

Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:

§5719. Housing Stabilization Services

A. Housing stabilization services enable waiver beneficiaries to maintain their own housing as set forth in a beneficiary's approved plan of care. Services must be provided in the home or a community setting. This service includes the following components:

1. conducting a housing assessment to identify the beneficiary's preferences related to housing (i.e., type, location, living alone or with someone else, accommodations needed, and other important preferences), and his/her needs for support to maintain housing, including:

a. – A.2. ...

3. developing an individualized housing stabilization service provider plan based upon the housing assessment that includes short- and long-term measurable goals for each issue, establishes the beneficiary's approach to meeting the goal, and identifies where other provider(s) or services may be required to meet the goal;

4. – 4.a. ...

5. providing ongoing communication with the landlord or property manager regarding the beneficiary's disability,

accommodations needed, and components of emergency procedures involving the landlord or property manager;

6. updating the housing support plan annually or as needed due to changes in the beneficiary's situation or status; and

7. if at any time the beneficiary's housing is placed at risk (e.g., eviction, loss of roommate or income), providing supports to retain housing or locate and secure housing to continue community-based supports, including locating new housing, sources of income, etc.

B. ...

C. Beneficiaries may not exceed 165 combined units of this service and the housing stabilization transition service.

1. ...

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 40:81 (January 2014), amended 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 48:

§5721. Dental Services

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

1. adult diagnostic services;

2. preventative services;

3. restorative services;

4. endodontics;

5. periodontics;

6. prosthodontics;

7. oral and maxillofacial surgery;

8. orthodontics;

9. emergency care; and

10. adjunctive general services.

B. Dental Service Exclusions

1. Dental services are not available to beneficiaries who are 18 to 21 years of age as this group accesses dental services through the EPSDT benefit.

2. Non-covered services include but are not limited to the following:

a. services that are not medically necessary to the beneficiary’s dental health;

b. dental care for cosmetic reasons;

c. experimental procedures;

d. plaque control;

e. any periapical radiographic images, occlusal radiographic images, complete series, or panoramic radiographic images taken annually or routinely at the time of a dental examination for screening purposes;

f. routine post-operative services – these services are covered as part of the fee for initial treatment provided;

g. treatment of incipient or non-carious lesions (other than covered sealants and fluoride);

h. services that are eligible for reimbursement by insurance or covered under any other insurance or medical health plan;

i. dental expenses related to any dental services:

i. started after the beneficiary's coverage ended; or

ii. received before the beneficiary became eligible for these services; and

j. administration of in-office pre-medication.

C. Provider Qualifications. Providers are enrolled through the LA Dental Benefit Program, which is responsible for maintaining provider lists.

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 48:

Chapter 59. Provider Participation

§5901. General Provisions

A. ...

B. If transportation is provided as part of a service, the provider must have insurance coverage on any vehicles used in transporting a beneficiary that meets current home and community-based services providers licensing standards.

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

1. ...

2. Supported Employment Services. The provider must possess a valid certificate of compliance as a community rehabilitation provider (CRP) from an approved program or the certification and training as required per OCDD.

3. – 6. ...

7. Dental Services. Providers of this service are managed through the LA Dental Benefit Program and must have a current, valid license from the State Board of Dentistry.

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), LR 48:

§5903. Electronic Visit Verification

A. ...

B. Reimbursement shall only be made to providers with use of the EVV system. The services that require use of the EVV system include the following: center-based respite, day habilitation, prevocational services and supported employment services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:1288 (July 2015) , amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:

Chapter 61. Reimbursement

§6101. Unit of Reimbursement

A. ...

B. Supported Employment Services. Reimbursement shall be a prospective flat rate for each approved unit of service provided to the beneficiary. A standard unit of service in both individual and group job assessment, discovery and development is one-quarter hour (15 minutes). A standard unit of service in individual initial job support, job retention and follow-along is one-quarter hour (15 minutes). A standard unit of service in group initial job support, job retention and follow-along is one hour or more per day.

C. Day Habilitation. Reimbursement shall be a prospective flat rate for each approved unit of service provided to the beneficiary. A standard unit of service is one-quarter hour (15 minutes).

D. Prevocational Services. Reimbursement shall be a prospective flat rate for each approved unit of service provided to the beneficiary. A standard unit of service is one-quarter hour (15 minutes).

E. Respite, housing stabilization transition services and housing stabilization services shall be reimbursed at a prospective flat rate for each approved unit of service provided

to the beneficiary. One-quarter hour (15 minutes) is the standard unit of service.

F. Habilitation. Reimbursement shall be a prospective flat rate for each approved unit of service provided to the beneficiary. One-quarter hour (15 minutes) is the standard unit of service.

G. - I. ...

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

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), amended LR 34:662 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 36:2281 (October 2010), LR 37:2158 (July 2011), LR 39:1050 (April 2013), LR 40:82 (January 2014), LR 40:2587 (December 2014), 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 48:43 (January 2022), LR 48:

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.

Dr. Courtney N. Phillips

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Hospital Licensing Standards
(LAC 48:I.9336 and 9391)

The Department of Health, Bureau of Health Services Financing has adopted LAC 48.I.9336 and amended §9391 as authorized by R.S. 36:254, R.S. 29:760 and R.S. 40:1061.9. 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 48

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

Chapter 93. Hospitals

Subchapter B. Hospital Organization and Services

§9336. Visitation by Members of the Clergy During a Declared Public Health Emergency

A. For purposes of this Section, a public health emergency (PHE) is a declaration made pursuant to the Louisiana Health Emergency Powers Act, R.S. 29:760 et seq.

B. A licensed hospital shall comply with any federal law, regulation, requirement, order, or guideline that is more restrictive than this Section regarding visitation in hospitals during a declared PHE issued by any federal government agency.

C. For purposes of this Section, clergy shall be defined as follows:

1. a minister, priest, preacher, rabbi, imam, Christian Science practitioner; or

2. other similar functionary of a religious organization; or

3. an individual reasonably believed so to be by the person consulting him.

D. The provisions of this Section regarding visitation by members of the clergy shall apply to all hospitals licensed by the Department of Health, except for a licensed hospital that is designated as a forensic facility.

E. Subject to compliance with the requirements of this Section, each hospital shall allow members of the clergy to visit patients of the hospital during a declared PHE when a patient, or his legal or designated representative, requests a visit with a member of the clergy, subject to the following conditions and requirements:

1. each hospital shall have a written policy and procedure addressing visitation by members of the clergy. A copy of the written policy and procedure shall be available, without cost, to the patient and his legal or designated representative, upon request. The hospital shall provide a link

to an electronic copy of the policy and procedure to a member of the clergy, upon request.

2. a hospital’s policy and procedure regarding clergy visitation may adopt reasonable time, place, and manner restrictions, provided that such restrictions are implemented by the hospital, in consultation with appropriate medical personnel, for the purpose of mitigating the possibility of transmission of any infectious agent or infectious disease or for the purpose of addressing the medical condition or clinical considerations of an individual patient.

3. a hospital’s policy and procedure on clergy visitation shall, at a minimum, require the following:

a. that the hospital give special consideration and priority for clergy visitation to patients receiving end-of-life care;

b. that a clergy member will be screened for infectious agents or infectious diseases, utilizing at least the current screening or testing methods and protocols recommended by the Centers for Disease Control and Prevention, as applicable;

c. that a clergy member not be allowed to visit a hospital patient if such clergy member has obvious signs or symptoms of an infectious agent or infectious disease, or if

such clergy member tests positive for an infectious agent or infectious disease;

d. that a clergy member not be allowed to visit a hospital patient if the clergy member refuses to comply with the provisions of the hospital's policy and procedure or refuses to comply with the hospital's reasonable time, place, and manner restrictions;

e. that a clergy member be required to wear personal protective equipment as determined appropriate by the hospital, considering the patient's medical condition or clinical considerations. At the hospital's discretion, personal protective equipment may be made available by the hospital to clergy members;

f. that a hospital's policy and procedure include provisions for compliance with a state health officer (SHO) order limiting visitation during a declared PHE; and

g. that a hospital's policy and procedure include provisions for compliance with any federal law, regulations, requirements, orders, or guidelines regarding visitation in hospitals during a declared public health emergency issued by any federal government agency that are more restrictive than this Section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 29:760.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:

§9391. Registers and Reports

A. – A.8. ...

B. All hospitals licensed by the Department of Health that provide emergency treatment, due to complications following an abortion as defined in R.S. 40:1061.9 shall:

1. ensure proper electronic coding and tracking of post-abortion complications;

2. submit to the department, on a form provided by the department, a report on patients who present for post-abortion complication emergency treatment. The report shall:

a. be confidential;

b. be exempt from disclosure pursuant to the Public Records Law, R.S. 44:1 et seq.;

c. not contain the name or address of the patient;

d. include the following:

i. the date of the abortion;

ii. the name and address of the facility where the abortion was performed or induced;

iii. the nature of the abortion complication diagnosed or treated;

iv. the name and address of the facility where the post-abortion care was performed; and

3. ensure that a staff member of the hospital attempts to obtain the information required in this Section from any patient prior to the patient's discharge from the hospital.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:1061.9.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2416 (November 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 48:

Dr. Courtney N. Phillips

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Intermediate Care Facilities for
Persons with Intellectual Disabilities
Reimbursement Methodology
Direct Care Floor
(LAC 50:VII.32901)

The Department of Health, Bureau of Health Services Financing has amended the LAC 50:VII.32901 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 VII. Long Term Care
Subpart 3. Intermediate Care Facilities for Persons with Intellectual Disabilities

Chapter 329. Reimbursement Methodology

Subchapter A. Non-State Facilities

§32901. Cost Reports

A. – B.2. ...

C. Direct Care Floor

1. ...

2. For providers receiving pervasive plus supplements in accordance with §32903.H or other client specific adjustments to the rate in accordance with §32903.I, the

facility wide direct care floor is established at 94 percent of the per diem direct care payment and at 100 percent of any rate supplements or add-on payments received by the provider, including the pervasive plus supplement, the complex care add-on payment and other client specific adjustments to the rate. The direct care floor will be applied to the cost reporting year in which the facility receives a pervasive plus supplement and/or a client specific rate adjustment. In no case, however, shall a facility receiving a pervasive plus supplement and/or client specific rate adjustment have total facility payments reduced to less than a safe harbor percentage of 104 percent of the total facility cost as a result of imposition of the direct care floor, except as noted in §32901.C.4.a.

3. For providers receiving complex care add-on payment in accordance with §32915, but not receiving pervasive plus supplements in accordance with §32903.H or other client specific adjustments to the rate in accordance with §32903.I, the facility wide direct care floor is established at 85 percent of the per diem direct care payment and at 100 percent of the complex care add-on payment. The direct care floor will be applied to the cost reporting year in which the facility receives a complex care add-on payment. In no case shall a facility receiving a complex care add-on payment have total facility payments reduced to less than a safe harbor percentage

of 104 percent of the total facility cost as a result of imposition of the direct care floor, except as noted in §32901.C.4.a.

4. For facilities for which the direct care floor applies, if the direct care cost the facility incurred on a per diem basis is less than the appropriate facility direct care floor, the facility shall remit to the bureau the difference between these two amounts times the number of facility Medicaid days paid during the cost reporting period. This remittance shall be payable to the bureau upon submission of the cost report.

a. For dates of service on or after July 1, 2022, if a provider receiving complex care or pervasive plus add-on payments in accordance with §32915 or §32903.H, respectively, has facility payments reduced as a result of imposition of the direct care floor, the department may, at its discretion, levy a non-refundable administrative penalty separate from any other reduction in facility payments. The administrative penalty is not subject to any facility specific safe harbor percentage specified in §32901.C, and is calculated solely on the final reduced payment amount for the cost report period in question. Under LAC 50.I.4147 of the Surveillance and Utilization Review Subsystem (SURS) Rule, the department may impose sanctions for noncompliance with Medicaid laws,

regulations, rules, and policies. Facilities who have payments reduced as a result of imposition of the direct care floor that have consecutive subsequent years of reduced payments shall have the following safe harbor and administrative penalty impacts:

Consecutive Cost Report Period with Reduced Payments	**Administrative Penalty Levied on Reduced Payments**	**Safe Harbor Percentages**
1st Year	0 percent	104 percent
2nd Year	0 percent	102 percent
3rd Year	5 percent	100 percent
4th Year and Onwards	10 percent	100 percent

b. At its discretion, LDH may terminate provider participation in the complex care or pervasive plus add-on payment programs as a result of imposition of the direct care floor.

5. Upon completion of desk reviews or audits, facilities will be notified by the bureau of any changes in amounts due based on audit or desk review adjustments.

a. Direct care floor recoupment and/or administrative penalty assessed as a result of a facility not meeting the required direct care per diem floor is considered effective 30 days from the issuance of the original notice of determination. Should an informal reconsideration be requested, the recoupment and/or penalty will be considered effective 30 days from the issuance of the results of an informal hearing. The filing of a timely and adequate notice of an administrative

appeal does not suspend or delay the imposition of a recoupment(s) and/or penalty.

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 31:1592 (July 2005), repromulgated LR 31:2252 (September 2005), amended LR 33:461 (March 2007), amended by the Department of Health, Bureau of Health Services Financing, LR 44:1446 (August 2018), LR 46:28 (January 2020), LR 47:1124 (August 2021), LR 48:

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.

Dr. Courtney N. Phillips

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Pharmacy Benefits Management Program
Over-the-Counter At-Home COVID-19 Tests
(LAC 50:XXIX.107)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XXIX.107 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

§107. Prior Authorization

A. – C.3. ...

D. Drugs Excluded from Coverage. As provided by §1927(d)(2) of the Social Security Act, the following drugs are excluded from program coverage:

1. – 4.o. ...

5. select nonprescription drugs except OTC antihistamines and antihistamine/decongestant combinations and

polyethylene glycol 3350 (Miralax®) and OTC at-home COVID-19 FDA-authorized tests;

E. – E.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S, 36:254, Title XIX of the Social Security Act, and the 1995-96 General Appropriations Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1053 (June 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1180 (June 2017), LR 43:1553 (August 2017), amended LR 45:665 (May 2019), LR 46:33 (January 2020), LR 48:

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.

Dr. Courtney N. Phillips

Secretary