# Subpart 15. Adult Residential Care

## Chapter 301. General Provisions

### §30101. Introduction

A. These standards for participation specify the requirements of the Adult Residential Care (ARC) Waiver Program. The program is funded as a waiver service under the provisions of Title XIX of the Social Security Act and is administrated by the Department of Health and Hospitals (DHH).

B. Waiver services are provided under the provisions of the approved waiver agreement between the Centers for Medicare and Medicaid Services (CMS) and the Louisiana Medicaid Program.

C. Any provider of services under the ARC Waiver shall abide by and adhere to any federal or state laws, rules or any policy, procedures, or manuals issued by the department. Failure to do so may result in sanctions.

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 of Aging and Adult Services, LR 35:2442 (November 2009).

### §30103. Target Population

A. The target population for the Adult Residential Care (ARC) Waiver shall be individuals who are:

1. 65 years of age or older or 21 or over with an adult onset disability (onset at age 21 or over);

2. meet the criteria for admission to a nursing facility; and

3. meet Medicaid financial eligibility.

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 of Aging and Adult Services, LR 35:2442 (November 2009).

### §30105. Request for Services Registry

A. The department is responsible for the Request for Services Registry, hereafter referred to as "the registry", for the Adult Residential Care Waiver. An individual who wishes to have his or her name placed on the registry shall contact a toll-free telephone number maintained by the department.

B. Individuals who desire placement on the registry shall be screened to determine whether they meet the requirements for nursing facility level of care. Only individuals who meet these criteria will be added to the registry.

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 of Aging and Adult Services, LR 35:2443 (November 2009).

### §30107. Programmatic Allocation of Waiver Opportunities

A. The ARC waiver shall be implemented in DHH Regions to be selected by the department based on provider interest. The department will allocate waiver capacity within the designated regions. Unused capacity will be reallocated to DHH regions that need additional capacity. If waiver capacity is exhausted in all DHH Regions, the central ARC Waiver registry procedure will be maintained.

B. When funding is appropriated for a new ARC Waiver opportunity or an existing opportunity is vacated, the department shall send a written notice to an individual on the registry indicating that a waiver opportunity is available and that the individual will be evaluated for a possible ARC Waiver opportunity assignment. An ARC Waiver opportunity is assigned to an individual when eligibility is established and the individual is certified eligible for Medicaid and the ARC Waiver.

C. ARC Waiver opportunities will be offered based on the date of first request for services with priority offered to individuals who are in a nursing facility, but could return to the community if ARC Waiver services are provided. Priority will also be offered to individuals currently enrolled in another Office of Aging and Adult Services (OAAS)-administered Medicaid waiver whose service needs no longer align with their current waiver program. Support coordinators will develop complementary, but not duplicative, transition plans to ensure seamless and efficient movement into the ARC Waiver from another program. OAAS shall reserve five to ten waiver opportunities for Adult Protective Services/Elderly Protective Services cases for individuals who are substantiated as victims of abuse, neglect, exploitation and extortion and are in need of the ARC Waiver.

D. The remaining waiver opportunities, if any, are offered on a first-come, first-serve basis to individuals who qualify for a nursing facility level of care.

E. If the applicant is determined to be ineligible for any reason, the next individual on the registry is notified as stated above and the process continues until an individual is determined eligible.

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 of Aging and Adult Services, LR 35: 2443 (November 2009).

### §30109. Waiver Costs Limit

A. In order to assure the cost effectiveness of the ARC Waiver, each participant shall have access to ARC waiver services unless the ARC waiver costs exceed 150 percent of nursing facility costs for six or more months. Efforts will be made to understand cost drivers and to preserve waiver participation before disenrollment.

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 of Aging and Adult Services, LR 35:2443 (November 2009).

# Chapter 303. Services

## §30301. Covered Services

A. The following services are available to participants in the ARC Waiver. All services must be provided in accordance with the participant's approved comprehensive plan of care (CPOC). Reimbursement shall not be made for ARC Waiver services provided prior to the department's approval of the CPOC.

1. Support Coordination. Support coordination services assist individuals in gaining access to necessary waiver and State Plan services, as well as needed social, educational and other services, regardless of the funding source for these services. Support coordinators shall be responsible for ongoing monitoring of the provision of services included in the participant's approved CPOC.

a. All ARC Waiver participants must receive support coordination services.

b. The support coordinator shall complete a CPOC which contains the type and number of services, including waiver and all other services, necessary to maintain the waiver participant safely in the community.

c. The support coordinator shall complete the initial and annual assessment designated by the department.

d. Comprehensive plans of care and initial and annual assessments must be completed and submitted timely in accordance with DHH policy and procedures.

2. Intensive Support Coordination. Intensive support coordination services assist individuals who are currently residing in nursing facilities to transition into an ARC placement or support individuals who have been admitted into inpatient hospitals in gaining access to necessary waiver and State Plan services, as well as needed social, educational and other services, regardless of the funding source for these services or to ensure that they transition back into the community, if possible.

a. Support coordinators will not receive reimbursement for intensive support coordination before prior authorization is given. Support coordinators will initiate and oversee the process for assessment and reassessment, as well as be responsible for ongoing monitoring of the provision of services included in the recipient's approved CPOC.

b. Service Limitations. Provision of nursing facility transition intensive support coordination is limited up to six months as approved by the department. All other intensive support coordination is limited up to 45 days.

3. Adult Residential Care Services. Adult residential care services is a coordinated array of supportive personal care services, availability of 24-hour supervision and assistance, both scheduled and unscheduled assistance, age and ability appropriate activities, and health related services designed to accommodate individual resident's changing needs and preference, to maximize the resident's dignity, autonomy, privacy and independence, and to encourage family and community involvement.

a. These services shall include, but are not limited to:

i. meals;

ii. laundry;

iii. social activities;

iv. assistance with transportation;

v. direct care services

vi. health care services

vii. 24-hour supervision and care; and

viii. intermittent nursing care.

b. It is the responsibility of the ARC facility to arrange for or provide transportation to recreational and social activities as well as medical appointments. ARC providers must receive prior authorization from OAAS before delivering ARC services.

c. ARC residents shall have private rooms.

i. Single occupancy must be assured by ARC providers.

ii. Sharing of units by individuals who are unrelated is permitted, however requests must be originated by the resident. Support coordinators must authorize sharing of residential units and document that the request was originated by the resident prior to units being shared.

4. Community Transition Benefit. Individuals transitioning into ARC residential settings may be faced with many one-time expenses. The community transition benefit provides assistance with one-time costs associated with establishing a residence. Prior authorization will be required for all community transition benefit expenditures.

a. The community transition benefit may only be used to purchase needed items that the waiver participant does not already own or that the ARC provider is not required by law or rule to provide.

b. Expenses of security deposits, utility set up fees (e.g., telephone, electric, heating, water) shall be allowable in ARC facilities utilizing specific types of federal funding.

c. Items not considered essential include recreational items such as televisions, cable TV, DVD players, stereos, etc.

d. The community transition benefit is capped at $3,000 during a participant's tenure in the waiver. The benefit may be accessed up to a maximum of three times over the course of their participation in the waiver.

B.

ARC Waiver participants may not participate in comparable Medicaid long-term care services including, but

not limited to, Medicaid-financed home health care and long term personal care 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 of Aging and Adult Services, LR 35:2243 (November 2009).

**§30303. Comprehensive Plan of Care**

A. The comprehensive plan of care (CPOC) is a written agreement that specifies the long-range goals, short-term objectives, specific action steps or services, assignment of responsibility, and time frames for completion or review.

B. Reimbursement shall not be made for ARC Waiver services provided prior to the department's approval of the CPOC. All services and related support coordinator and ARC billing must align with the CPOC.

C. The support coordinator shall complete a CPOC which shall contain:

1. services that meet the needs and objectives and the health, safety and welfare of the individual; and

2. waiver services based on the assessment necessary to maintain the participant safely in the community.

D. Staff or contracted registered nurses (RN) with support coordination agencies will review all Minimum Data Set-Home Care (MDS-HC) assessments and related plans prior to submission to the department for prior authorization.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2444 (November 2009).

# Chapter 305. Admission and Discharge Criteria

**§30501. Admission Criteria**

A. Admission to the ARC Waiver Program shall be determined in accordance with the following criteria:

1. initial and continued Medicaid financial eligibility;

2. initial and continued eligibility for a nursing facility level of care;

3. justification, as documented in the approved CPOC, that ARC Waiver services are appropriate and cost-effective; and

4. assurance that the health and welfare of the individual can be maintained in the community with the provisions of the ARC Waiver services.

B. Failure of the individual to cooperate in the eligibility determination process or to meet any of the criteria above will result in denial of admission to the ARC waiver.

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 of Aging and Adult Services, LR 35:2444 (November 2009).

**§30503. Admission Denial or Discharge Criteria**

A. Admission shall be denied or the participant shall be discharged from the ARC waiver program if any one of the following conditions is determined:

1. the individual does not meet the criteria for Medicaid financial eligibility;

2. the individual does not meet the criteria for a nursing facility level of care;

3. the participant is incarcerated or placed under the jurisdiction of penal authorities or courts;

4. the participant has a change of residence to another state;

5. the participant fails to comply with lease/admission agreement;

6. the health, safety and welfare of the individual cannot be assured through the provision of ARC services within the individual's cost effectiveness, including, but not limited to:

a. the individual refusing waiver services delivered in accordance with his or her CPOC; or

b. the individual not agreeing to enter into or comply with negotiated risk agreements as determined by an assessment performed by the support coordinator and conditions incorporated into the CPOC and ARC provider service plan;

7. the individual fails to cooperate in the eligibility determination process or in the performance of the CPOC;

8. failure on behalf of the participant to maintain a safe and legal home environment;

9. it is not cost effective to serve the individual in the ARC Waiver;

10. the participant develops a permanent or long-term medical condition or needs a medical treatment, permanently or for an extended period, that is not appropriate for the ARC program; or

11. continuity of services is interrupted as a result of the participant not receiving ARC Waiver services, exclusive of support coordination, during the period of 30 consecutive days.

B. A resident may not be discharged if a participant has paid room and board/rent and leaves the facility for any reason during the time they are enrolled in the waiver.

C. The ARC Waiver will not make service ("bed-hold") payments to an ARC provider while a participant is not in 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 of Aging and Adult Services, LR 35:2444 (November 2009).

# Chapter 307. Provider Participation

### §30701. ARC Provider Responsibilities

A. Each ARC provider must meet adult residential care provider licensure and certification standards set forth by the Louisiana Department of Health and Hospitals, Bureau of Health Services Financing, Health Standards Section. ARC providers must be in good standing with licensure.

B. All enrolled adult residential care facilities and nursing facilities that are converting units/beds to ARC units must demonstrate commitment to resident-centered/culture change principles. Resident centered or culture change organizations are those that are considered to have:

1. close relationships existing between residents, family members, staff, and community;

2. residents direct their own care and living choices (e.g., daily schedules, food choices, other decisions);

3. personnel organized around the needs and desires of clients rather than by departments;

4. management that allows collaborative and group decision making;

5. processes/measures that are used for continuous quality improvement; and

6. a living environment that is designed to be a home rather than an institution.

C. All ARC providers must have OAAS approved negotiated risk agreement procedures and negotiated risk agreement templates before they are enrolled as waiver providers. If, during the assessment or the development of the CPOC or service plan, there is a need for a negotiated risk agreement as a condition of residency, the agreement elements shall be incorporated into the CPOC. Support coordinators shall review any subsequent negotiated risk agreements and incorporate risk agreement elements in the plan of care as necessary.

D. ARC providers are required to set aside operating funds to account for shortfalls that arise due to various causes.

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 of Aging and Adult Services, LR 35:2442 (November 2009).

### §30703. Support Coordination Agency Responsibilities

A. The support coordination agency must meet case management licensing standards set forth by the Louisiana Department of Health and Hospitals, Health Standards Section and must enter into a provider enrollment agreement as specified by the department.

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 of Aging and Adult Services, LR 35:2445 (November 2009).

### §30705. Reporting Requirements

A. Support coordinators and direct service providers, including ARC providers, are obligated to report changes to the department that could affect the waiver participant's eligibility including, but not limited to, those changes cited in the denial or discharge criteria.

B. Support coordinators and direct service providers, including ARC providers, are responsible for documenting the occurrence of incidents or accidents that affect the health, safety and welfare of the participant and completing an incident report. Incident reports shall be submitted to the department in accordance with the specified requirements. Categories of critical incidents include but are not limited to:

1. abuse;

2. neglect;

3. misappropriation of property; and

4. extortion.

C. Support coordinators will speak with ARC participants at least monthly and will meet face-to-face with ARC providers and recipients at least quarterly to review and update (as needed) the ARC Service Plan. Such required contact shall be documented in the support coordinator's records and in the appropriate electronic reporting systems.

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 of Aging and Adult Services, LR 35:2445 (November 2009).

### §30707. Recordkeeping

A. An ARC facility's employee records must contain the verification of the hours worked by individual employees which may be sign-in sheets or time cards, but shall indicate the specific time the employee clocked in and out for all employees, even those persons employed on a contractual or consultant basis.

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 of Aging and Adult Services, LR 35:2445 (November 2009).

# Chapter 309. Reimbursement

### §30901. General Provisions

A. ARC Services. Louisiana Medicaid participating providers that are licensed and certified to provide ARC services to Medicaid eligible individuals will be reimbursed for these services on a per diem basis as described in this Chapter. Specific rates will be paid based on assessment acuity levels established on RUG-III grouped into three or more tiers.

B. Payments to ARC facilities for the waiver services will be based on the MDS-HC Resource Use Group-III/Home Care (RUG-III/HC) algorithm, which classifies individuals based on their intensity of resource need. The RUG-III/HC system has been derived from the RUG-III payment system now used by Louisiana Medicaid to reimburse nursing facilities and will support the integration of a common payment methodology into a new service setting.

C. Medicaid is prohibited from making "bed-hold" payments when a resident enters a facility.

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 of Aging and Adult Services, LR 35:2446 (November 2009).

**§30903. Provider Reimbursement**

A. The rate paid for ARC services shall be based on a percentage of the July 1 statewide average nursing facility case-mix rate after removing the provider fee component and the patient liability amount.

B. Support coordination services shall be reimbursed at a flat fee for each approved unit of service.

C. Personal Emergency Response Systems shall be reimbursed at a $30.00 initial installation fee and a $27.00 monthly maintenance fee.

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 of Aging and Adult Services, LR 35:2446 (November 2009).

**§30905. Room and Board**

A. Participants shall pay their room and board expenses directly to the ARC provider. The provider may only assess a maximum room and board charge for all Medicaid participants equal to the amount of Supplemental Security Income (SSI) minus the amount that DHH OAAS designates for personal needs allowance (PNA) sufficient for community living.

1. All ARC providers are required to execute an admission agreement/lease with residents and are prohibited from modifying the room and board without providing at least 30 days prior written notice to the resident.

2. If monthly room and board is paid to the facility by the resident, that resident may not be involuntarily discharged by the facility.

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 of Aging and Adult Services, LR 35:2446 (November 2009).

**§30907. Cost Reporting**

A. Adult Residential Care providers shall be required to file annual cost reports for evaluation by the department. Cost reports shall be filed as follows:

1. The cost report schedules will be provided by the department and must be submitted annually. The due date for filing annual cost reports is the last day of the fifth month following the facility's fiscal year end.

a. There shall be no automatic extension of the due date for the filing of cost reports. If a provider experiences unavoidable difficulties in preparing its cost report by the prescribed due date, one 30-day extension may be permitted, upon approval by the department.

b. A request for extension must be submitted to the department in writing prior to the prescribed due date of the cost report. Habitual requests for extensions will be considered in the extension evaluation by the department. The request must explain in detail why the extension is necessary. Extensions beyond 30 days may be approved for situations beyond the facility's control. An extension will not be granted when the provider agreement is terminated or a change in ownership occurs.

B. For failure to file a cost report by the prescribed due date, a penalty of five percent of the total monthly payment for each month of non-compliance may be levied. The penalty may be a progressive penalty of five percent for each succeeding month of non-compliance.

C. The cost report must be prepared in accordance with instructions provided by the department using the definition of allowable and non-allowable cost contained in the most current version of the Medicare Provider Reimbursement Manual, 15-I as of the end of the cost report period.

D. Separate cost reports must be submitted by central/home offices when costs of the central/home office are reported in the facility's cost report.

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 of Aging and Adult Services, LR 35:2446 (November 2009).