Subpart 7. Community Choices Waiver

Chapter 81. General Provisions

§8101. Introduction

A. The target population for the Community Choices Waiver includes individuals who:

1. are currently in the Elderly and Disabled Adults Waiver as of September 30, 2011;

2. are 65 years of age or older; or

3. are 21-64 years of age with a physical disability; and

4. meet nursing facility level of care requirements.

B. 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. Requests for Community Choices Waiver services shall be accepted from the following:

1. an individual requestor/applicant;

2. an individual who is legally responsible for a requestor/applicant; or

3. a responsible representative designated by the requestor/applicant to act on his/her behalf.

D. Each individual who requests Community Choices Waiver services has the option to designate a responsible representative. For purposes of these provisions, a responsible representative shall be defined as the person designated by the individual to act on his/her behalf in the process of accessing and/or maintaining Community Choices Waiver services.

1. The appropriate form authorized by the Office of Aging and Adult Services (OAAS) shall be used to designate a responsible representative.

a. The written designation of a responsible representative does not take away the right of the individual to continue to transact business on his/her own behalf nor does it give the representative any legal authority other than as specified in the designation form.

b. The written designation is valid until revoked by the individual granting the designation. To revoke the written designation, the revocation must be submitted in writing to OAAS or its designee.

2. The functions of a responsible representative are to:

a. assist and represent the individual in the assessment, care plan development and service delivery processes; and

b. to aid the participant in obtaining all of the necessary documentation for these processes.

3. No individual may concurrently serve as a responsible representative for more than two participants in OAAS-operated Medicaid home and community-based service programs. This includes but is not limited to:

a. the Program of All-Inclusive Care for the Elderly;

b. long-term personal care services;

c. the Community Choices Waiver; and

d. the Adult Day Health Care 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 37:3517 (December 2011), amended LR 40:791 (April 2014).

§8103. Request for Services Registry

A. The Department of Health and Hospitals (DHH) is responsible for the request for services registry, hereafter referred to as "the registry," for the Community Choices Waiver. An individual who wishes to have his or her name placed on the registry must contact a toll-free telephone number which shall be maintained by the department.

B. Individuals who desire their name to be placed on the Community Choices Waiver registry shall be screened to determine whether they meet nursing facility level of care. Only individuals who pass this screen shall 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 37:3517 (December 2011).

§8105. Programmatic Allocation of Waiver Opportunities

A. When funding is available for a new Community Choices 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. If the individual accepts the opportunity, that individual shall be evaluated for a possible Community Choices Waiver opportunity assignment.

B. Community Choices Waiver opportunities shall be offered to individuals on the registry according to priority groups. The following groups shall have priority for Community Choices Waiver opportunities, in the order listed:

1. individuals with substantiated cases of abuse or neglect referred by Adult Protective Services (APS) or Elderly Protective Services (EPS) who, without Community Choices Waiver services, would require institutional placement to prevent further abuse or neglect;

2. individuals diagnosed with Amyotrophic Lateral Sclerosis (ALS), also known as Lou Gehrig's disease;

3. individuals who are residing in a state of Louisiana permanent supportive housing unit or who are linked for the state of Louisiana permanent supportive housing process;

4. individuals admitted to a nursing facility who are approved for a stay of more than 90 days;

5. individuals who are not presently receiving home and community-based services (HCBS) under another approved Medicaid waiver program, including, but not limited to the:

a. adult day health care (ADHC) Waiver;

b. new opportunities waiver (NOW);

c. supports waiver, and/or

d. residential options waiver (ROW); and

6. all other eligible individuals on the request for services registry (RFSR), by date of first request for services.

C. If an applicant is determined to be ineligible for any reason, the next individual on the registry is notified as stated above and the process shall continue until an individual is determined eligible. A Community Choices Waiver opportunity is assigned to an individual when eligibility is established and the individual is certified.

D. Notwithstanding the priority group provisions, 75 community choices Waiver opportunities are reserved for qualifying individuals who have been diagnosed with Amyotrophic Lateral Sclerosis (ALS). Qualifying individuals who have been diagnosed with ALS shall be offered an opportunity on a first-come, first-serve basis.

E. Notwithstanding the priority group provisions, up to 300 community choices waiver opportunities may be granted to qualified individuals who require emergency waiver services. These individuals shall be offered an opportunity on a first-come, first-serve basis.

1. To be considered for an expedited waiver opportunity, the individual must, at the time of the request for the expedited opportunity, be approved for the maximum amount of services allowable under the Long Term Personal Care Services Program and require institutional placement, unless offered an expedited waiver opportunity.

2. The following criteria shall be considered in determining whether or not to grant an emergency waiver opportunity:

a. support through other programs is either unavailable or inadequate to prevent nursing facility placement;

b. the death or incapacitation of an informal caregiver leaves the person without other supports;

c. the support from an informal caregiver is not available due to a family crisis;

d. the person lives alone and has no access to informal support; or

e. for other reasons, the person lacks access to adequate informal support to prevent nursing facility placement.

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 37:3517 (December 2011), amended LR 39:319 (February 2013), LR 39:1778 (July 2013).

§8107. Resource Assessment Process

A. Each community choices waiver applicant/participant shall be assessed using a uniform assessment tool called the minimum data set-home care (MDS-HC). The MDS-HC is designed to verify that an individual meets nursing facility level of care and to assess multiple key domains of function, health, social support and service use. The MDS-HC assessment generates a score that assigns the individual to a resource utilization group (RUG-III/HC).

B. The following seven primary RUG-III/HC categories and subcategories will be utilized to determine the assistance needed for various activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

1. Special Rehabilitation. Individuals in this category have had at least 120 minutes of rehabilitation therapy (physical, occupational and/or speech) within the seven days prior to their MDS-HC assessment.

2. Extensive Services. Individuals in this category have a medium to high level of need for assistance with ADLs and require one or more of the following services:

a. tracheostomy;

b. ventilator or respirator; or

c. suctioning.

3. Special Care. Individuals in this category have a medium to high level of need for assistance with ADLs and have one or more of the following conditions or require one or more of the following treatments:

a. stage 3 or 4 pressure ulcers;

b. tube feeding;

c. multiple sclerosis diagnosis;

d. quadriplegia;

e. burn treatment;

f. radiation treatment;

g. IV medications; or

h. fever and one or more of the following conditions:

i. dehydration diagnosis;

ii. pneumonia diagnosis;

iii. vomiting; or

iv. unintended weight loss.

4. Clinically Complex. Individuals in this category have the following specific clinical diagnoses or require the specified treatments:

a. dehydration;

b. any stasis ulcer. A stasis ulcer is a breakdown of the skin caused by fluid build-up in the skin from poor circulation;

c. end-stage/terminal illness;

d. chemotherapy;

e. blood transfusion;

f. skin problem;

g. cerebral palsy diagnosis;

h. urinary tract infection;

i. hemiplegia diagnosis. Hemiplegia diagnosis shall include a total or partial inability to move, experienced on one side of the body, caused by brain disease or injury;

j. dialysis treatment;

k. diagnosis of pneumonia;

l. one or more of the eight criteria in special care (with low ADL need); or

m. one or more of the three criteria in extensive services (with low ADL need).

5. Impaired Cognition. Individuals in this category have a low to medium need for assistance with ADLs and impairment in cognitive ability. This category includes individuals with short-term memory loss, trouble in decision-making, difficulty in making themselves understood by others and difficulty in eating performance.

6. Behavior Problems. Individuals in this category have a low to medium need for assistance with ADLs and behavior problems. This category includes individuals that may have socially inappropriate behavior, are physically or verbally abusive, have hallucinations or exhibit wandering behavior.

7. Reduced Physical Function. Persons in this category do not meet the criteria in one of the previous six categories.

C. Based on the RUG III/HC score, the applicant/participant is assigned to a level of support category and is eligible for a set annual services budget associated with that level.

1. If the applicant/participant disagrees with his/her annual services budget, the applicant/participant or his/her responsible representative may request a fair hearing to appeal the decision.

2. The applicant/participant may qualify for an increase in the annual services budget amount upon showing that:

a. one or more answers are incorrect as recorded on the MDS-HC (except for the answers in sections AA, BB, A, and R); or

b. he/she needs an increase in the annual services budget to avoid entering into a nursing facility.

D. Each community choices waiver participant shall be re-assessed at least annually.

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 37:3518 (December 2011).

Chapter 83. Covered Services

§8301. Support Coordination

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

1. intake;

2. assessment;

3. plan of care development and revision;

4. linkage to direct services and other resources;

5. coordination of multiple services among multiple providers;

6. monitoring and follow-up;

7. reassessment;

8. evaluation and re-evaluation of the level of care and need for waiver services;

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

10. responding to participant crises;

11. critical incident management; and

12. transition/discharge and closure.

B. Support coordinators shall provide information and assistance to waiver participants in directing and managing their services.

1. When participants choose to self-direct their waiver services, the support coordinators are responsible for informing participants about:

a. their responsibilities as an employer;

b. how their activities as an employer are coordinated with the fiscal agent and support; and

c. their responsibility to comply with all applicable state and federal laws, rules, policies, and procedures.

2. Support coordinators shall be available to participants for on-going support and assistance in these decision-making areas and with employer responsibilities.

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 37:3519 (December 2011), amended LR 39:319 (February 2013), LR 39:1778 (July 2013).

§8302. Long-Term Personal Care Services

A. Community choices waiver participants cannot also receive 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 39:320 (February 2013).

§8303. Transition Intensive Support Coordination

A. Transition intensive support coordination is services that will assist participants who are currently residing in nursing facilities in gaining access to needed waiver and other state plan services, as well as needed medical, social, housing, educational and other services, regardless of the funding source for these services. Support coordinators shall 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 participant's approved POC.

1. This service is paid for up to six months prior to transition from the nursing facility when adequate pre-transition supports and activities are provided and documented.

2. The scope of transition intensive support coordination shall not overlap with the scope of support coordination.

B. Support coordinators may assist persons to transition for up to 180 days while the individual still resides in 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 37:3519 (December 2011).

§8305. Environmental Accessibility Adaptations

A. Environmental accessibility adaptations are necessary physical adaptations that will be made to the home to reasonably assure the health and welfare of the participant, or enable the participant to function with greater independence in the home. Without these necessary adaptations, the participant would require institutionalization.

1. There must be an identified need for environmental accessibility adaptations as indicated by the MDS-HC.

a. Once identified by MDS-HC, a credentialed assessor must verify the need for, and draft job specifications including quotes for, the environmental accessibility adaptation(s).

b. A credentialed assessor must ensure that the environmental accessibility adaptation(s) meets all specifications before payment shall be made to the contractor that performed the environmental accessibility adaptation(s).

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 37:3519 (December 2011), amended LR 39:320 (February 2013).

§8307. Personal Assistance Services

A. Personal assistance services (PAS) provide assistance and/or supervision necessary for the participant with functional impairments to remain safely in the community. PAS include the following services and supports based on the approved POC:

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 participant;

4. supervision or assistance with health related tasks (any health related procedures governed under the Nurse Practice Act)where the direct service worker has received proper training pursuant to R.S. 37:1031-1034;

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

6. extension of therapy services, defined as follows:

a. Licensed therapists may choose to instruct the attendants on the proper way to assist the participant in follow-up therapy sessions. This assistance and support provides reinforcement of instruction and aids in the rehabilitative process.

b. In addition, a registered nurse may instruct an attendant to perform basic interventions with a participant that would increase and optimize functional abilities for maximum independence in performing activities of daily living such as range of motion exercises.

B. PAS is provided in the participant's home or in another location outside of the home if the provision of these services allows the individual to participate in normal life activities pertaining to the ADLs and IADLs cited in the POC. IADLs may not be performed in the participant's home when the participant is absent from the home. There shall be no duplication of services. PAS may not be provided while the participant is admitted to or attending a program which provides in-home assistance with ADLs or IADLs or

while attending or admitted to a program or setting where such assistance is provided.

C. The provision of PAS services outside of the participant's home does not include trips outside of the borders of the state without prior written approval by OAAS or its designee, through the POC or otherwise.

D. PAS may be provided through the "a.m." and "p.m." delivery option defined as follows:

1. a minimum of one hour and a maximum of two hours of PAS provided to assist the participant at the beginning of his/her day, referred to as the "a.m." portion of this PAS delivery method; and

2. a minimum of one hour and a maximum of two hours to assist the participant at the end of his/her day, referred to as the "p.m." portion of this PAS delivery method; and

3. a minimum four hours break between the "a.m." and the "p.m." portions of this PAS delivery method; and

4. not to exceed a maximum of four hours of PAS being provided within a calendar day;

5. "a.m. and p.m." PAS cannot be "shared;"

6. it is permissible to receive only the "a.m." or "p.m." portion of PAS within a calendar day;

7. "a.m." and/or "p.m." PAS may not be provided on the same calendar day as other LT-PCS delivery methods;

8. PAS providers must be able to provide both regular and "a.m." and "p.m." PAS and cannot refuse to accept a Community Choices Waiver participant solely due to the type of PAS delivery method that is listed on the POC.

E. PAS may be provided by one worker for up to three waiver participants who live together and who have a common direct service provider. Wavier participants may share PAS staff when agreed to by the participants and as long as the health and welfare of each participant can be reasonably assured. Shared PAS is to be reflected in the POC of each participant. Reimbursement rates shall be adjusted accordingly.

F. A home health agency direct service worker who renders PAS must be a qualified home health aide as specified in Louisiana's minimum licensing standards for home health agencies.

G. Every PAS provider shall ensure that each waiver participant who receives PAS has a written individualized back-up staffing plan and agreement for use in the event that the assigned PAS worker is unable to provide support due to unplanned circumstances, including emergencies which arise during a shift. The individualized plan and agreement shall be developed and maintained in accordance with OAAS policy.

H. Every PAS provider shall ensure timely completion of the emergency plan for each waiver participant they serve in accordance with OAAS policy.

I. The following individuals are prohibited from being reimbursed for providing services to a participant:

1. the participant's spouse;

2. the participant's curator;

3. the participant's tutor;

4. the participant's legal guardian;

5. the participant's responsible representative; or

6. the person to whom the participant has given representative and mandate authority (also known as power of attorney).

J. Participants are not permitted to receive PAS while living in a home or property owned, operated, or controlled by an owner, operator, agent, or employee of a licensed provider of long-term care services and providers are prohibited from providing and billing for services under these circumstances. Participants may not live in the home of a direct support worker unless the direct support is related by blood or marriage to the participant.

1. The provisions of §8307.J may be waived with prior written approval by OAAS or its designee.

K. It is permissible for the PAS allotment to be used flexibly in accordance with the participant's preferences and personal schedule and OAAS' documentation requirements.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3519 (December 2011), amended LR 39:320 (February 2013), LR 39:1778 (July 2013), LR 40:791 (April 2014).

§8309. Transition Services

A. Transition Services are time limited, non-recurring set-up expenses available for individuals who have been offered and approved for a Community Choices Waiver opportunity and are transitioning from a nursing facility to a living arrangement in a private residence where the individual is directly responsible for his/her own living expenses.

B. Allowable expenses are those necessary to enable the individual to establish a basic household, excluding expenses for room and board, but includes:

1. security deposits that are required to obtain a lease on an apartment or house;

2. specific set up fees or deposits (telephone, electric, gas, water and other such necessary housing set up fees or deposits);

3. essential furnishings to establish basic living arrangements; and

4. health and welfare assurances (pest control/eradication, fire extinguisher, smoke detector and first aid supplies/kit).

C. These services must be prior approved in the participant's POC.

D. These services do not include monthly rental, mortgage expenses, food, monthly utility charges and household appliances and/or items intended for purely diversional/recreational purposes. These services may not be used to pay for furnishing or to set-up living arrangements that are owned or leased by a waiver provider.

E. Support coordinators shall exhaust all other resources to obtain these items prior to utilizing the waiver.

F. Funds are available one time per $1500 lifetime maximum for specific items as prior approved in the participant's POC.

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 37:3520 (December 2011).

§8311. Adult Day Health Care Services

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

B. ADHC services include:

1. meals, which shall not constitute a "full nutritional regimen" (three meals per day) but shall include a minimum of two snacks and a hot nutritious lunch;

2. transportation between the participant's place of residence and the ADHC in accordance with licensing standards;

3. assistance with activities of daily living;

4. health and nutrition counseling;

5. individualized exercise program;

6. individualized goal-directed recreation programs;

7. health education classes; and

8. individualized health/nursing services.

C. ADHC services may be provided no more than 10 hours per day and no more than 50 hours per week.

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 37:3521 (December 2011), amended LR 39:321 (February 2013).

§8315. Assistive Devices and Medical Supplies

A. Assistive devices and medical supplies are specialized medical equipment and supplies which include devices, controls, appliances, or nutritional supplements specified in the POC that enable participant to:

1. increase or maintain their abilities to perform activities of daily living; or

2. to perceive, control, or communicate with the environment in which they live or provide emergency response.

B. This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of assistive devices, and durable and non-

durable medical equipment. This service includes personal emergency response systems (PERS) and other in-home monitoring and medication management devices and technology.

C. This service may also be used for routine maintenance or repair of specialized equipment. Batteries, extended warranties, and service contracts that are cost effective may be reimbursed. This includes medical equipment not available under the state plan that is necessary to address participant functional limitations and necessary medical supplies not available under the state plan that are addressed in the POC.

D. Where applicable, participant must use Medicaid State Plan, Medicare, or other available payers first. The participant's preference for a certain brand or supplier is not grounds for declining another payer in order to access waiver services.

E. All services must be based on a verified need of the participant and the service must have a direct or remedial benefit to the participant with specific goals and outcomes. This benefit must be determined by an independent assessment on any items whose cost exceeds $500 and on all communication devices, mobility devices, and environmental controls. Independent assessments are done by the appropriate professional, *e.g.*, an occupational therapist, physical therapist, and/or speech-language pathologist, who has no fiduciary relationship with the manufacturer, supplier, or vendor of the item.

F. All items must reduce reliance on other Medicaid State Plan or waiver services.

G. All items must meet applicable standards of manufacture, design, and installation.

H. All items must be prior authorized and no experimental items shall be authorized.

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 37:3521 (December 2011), amended LR 39:321 (February 2013).

§8319. Non-Medical Transportation

A. Non-medical transportation is a service offered to enable waiver participants to participate in normal life activities pertaining to the IADLs cited in the POC and includes activities needed to facilitate transition to the community.

B. Waiver transportation services may not be used to:

1. replace unpaid caregivers, volunteer transportation, and other transportation services available to the individual;

2. replace services that are included in a service provider's reimbursement;

3. obtain items that can be delivered by a supplier or by mail-order; or

4. compensate the service provider for travel to or from the service provider's home.

C. This service shall be offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the state plan, defined at 42 CFR §440.170(a) (if applicable), and shall not replace them.

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 37:3522 (December 2011).

§8323. Skilled Maintenance Therapy

A. Skilled maintenance therapy is therapy services that may be received by community choices waiver participants in the home.

B. Skilled maintenance therapy services include physical therapy, occupational therapy, respiratory therapy and speech and language therapy.

C. Therapy services provided to recipients under the Community Choices Waiver are not necessarily tied to an episode of illness or injury and instead focus primarily on the person's functional need for maintenance of, or reducing the decline in, the participant's ability to carry out activities of daily living.

D. Skilled maintenance therapies may also be used to assess a participant's need for assistive devices or home modifications, training the participant and family members in the use of the purchased devices, performance of in-home fall prevention assessments, and participation on the POC planning team.

E. Services may be provided in a variety of locations including the participant's home or as approved by the POC planning team.

F. Skilled maintenance therapy services specifically include:

1. physical therapy services which promote the maintenance of, or the reduction in, the loss of gross/fine motor skills, and facilitate independent functioning and/or prevent progressive disabilities including:

a. professional assessment(s), evaluation(s) and monitoring for therapeutic purposes;

b. physical therapy treatments and interventions;

c. training regarding physical therapy activities, use of equipment and technologies;

d. designing, modifying or monitoring the use of related environmental modifications;

e. designing, modifying, and monitoring the use of related activities supportive to the POC goals and objectives; or

f. consulting or collaborating with other service providers or family members, as specified in the POC;

2. occupational therapy (OT) services which promote the maintenance of, or reduction in, the loss of fine motor skills, coordination, sensory integration, and/or facilitate the use of adaptive equipment or other assistive technology including:

a. teaching of daily living skills;

b. development of perceptual motor skills and sensory integrative functioning;

c. design, fabrication, or modification of assistive technology or adaptive devices;

d. provision of assistive technology services;

e. design, fabrication, or applying selected orthotic or prosthetic devices or selecting adaptive equipment;

f. use of specifically designed crafts and exercise to enhance function;

g. training regarding OT activities; and

h. consulting or collaborating with other service providers or family members, as specified in the POC;

3. speech language therapy (SLT) services which preserve abilities for independent function in communication, facilitate oral motor and swallowing function, facilitate use of assistive technology, and/or prevent progressive disabilities including:

a. identification of communicative or oropharyngeal disorders;

b. prevention of communicative or oropharyngeal disorders;

c. development of eating or swallowing plans and monitoring their effectiveness;

d. use of specifically designed equipment, tools, and exercises to enhance function;

e. design, fabrication, or modification of assistive technology or adaptive devices;

f. provision of assistive technology services;

g. adaptation of the participant's environment to meet his/her needs;

h. training regarding SLT activities; and

i. consulting or collaborating with other service providers or family members, as specified in the POC; and

4. respiratory therapy services which provide preventative and maintenance of airway-related techniques and procedures including:

a. application of medical gases, humidity and aerosols;

b. intermittent positive pressure;

c. continuous artificial ventilation;

d. administration of drugs through inhalation and related airway management;

e. individual care;

f. instruction administered to the waiver participant and informal supports; and

g. periodic management of ventilation equipment for participants whose ventilation care is performed by informal caregivers.

G. Where applicable, the participant must use Medicaid State Plan, Medicare, or other available payers first. The participant's preference for a certain therapist or agency is not grounds for declining another payer in order to access waiver services.

H. All services must be based on a verified need of the participant and the service must have a direct or remedial benefit to the participant with specific goals and outcomes. The authorized service will be reviewed/monitored by the support coordinator to verify the continued need for the service and that the service meets the participant's needs in the most cost effective manner.

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 37:3522 (December 2011), amended LR 39:321 (February 2013).

§8325. Housing Transition or Crisis Intervention Services

A. Housing transition or crisis intervention services enable participants who are transitioning into a permanent supportive housing unit, including those transitioning from institutions, to secure their own housing or provide assistance at any time the participant's housing is placed at risk (e.g., eviction, loss of roommate or income). The service includes the following components:

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

a. access to housing;

b. meeting the terms of a lease;

c. eviction prevention;

d. budgeting for housing/living expenses;

e. obtaining/accessing sources of income necessary for rent;

f. home management;

g. establishing credit; and

h. understanding and meeting the obligations of tenancy as defined in the lease terms;

2. assisting the participant to view and secure housing as needed. This may include arranging or providing transportation. The participant 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. includes short- and long-term measurable goals for each issue;

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

c. identifies where other provider(s) or services may be required to meet the goal;

4. participating in the development of the plan of care and incorporating elements of the housing support plan;

5. looking for alternatives to housing if permanent supportive housing is unavailable to support completion of transition; and

6. communicating with the landlord or property manager regarding the participant's disability, accommodations needed, and components of emergency procedures involving the landlord or property manager.

B. If at any time the participant's housing is placed at risk (e.g. eviction, loss of roommate or income), housing transition or crisis intervention 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.

C. This service is only available upon referral from the support coordinator. This 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 the State of Louisiana permanent supportive housing selection process.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:1779 (July 2013).

§8327. Housing Stabilization Services

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

1. participation in the plan of care renewal and updates as needed, incorporating elements of the housing support plan;

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

3. providing ongoing communication with the landlord or property manager regarding the participant's

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

4. updating the housing support plan annually or as needed due to changes in the participant's situation or status.

B. This service is only available upon referral from the support coordinator. This 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.

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 39:1779 (July 2013).

§8329. Monitored In-Home Caregiving Services

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

B. The principal caregiver is responsible for supporting the participant 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 participant;

4. supervision or assistance with health related tasks (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. Unless the individual is also the spouse of the participant, the following individuals are prohibited from being paid as a monitored in-home caregiving principal caregiver:

1. the participant's curator;

2. the participant's tutor;

3. the participant's legal guardian;

4. the participant's responsible representative; or

5. the person to whom the participant has given representative and mandate authority (also known as power of attorney).

D. Participants electing monitored in-home caregiving services shall not receive the following community choices waiver services during the period of time that the participant is receiving monitored in-home caregiving services:

1. personal assistance services;

2. adult day health care services; or

3. home delivered meal services.

E. Monitored in-home caregiving providers must be licensed HCBS providers with a monitored in-home caregiving module who employ professional staff, including a registered nurse and a care manager, to support principal caregivers to perform the direct care activities performed in the home. The agency provider must assess and approve the home in which services will be provided, and shall enter into contractual agreements with caregivers who the agency has approved and trained. The agency provider will pay per diem stipends to caregivers.

F. The MIHC provider must use secure, web-based information collection from principal caregivers for the purposes of monitoring participant 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 DHH HIPAA business associate addendum.

G. The Department of Health and Hospitals (DHH) shall reimburse for monitored in-home caregiving services based upon a two-tiered model which is designed to address the participant's acuity.

1. Monitored in-home caregiving services under tier 1 shall be available to the following resource utilization categories/scores as determined by the MDS-HC assessment:

a. special rehabilitation 1.21;

b. special rehabilitation 1.12;

c. special rehabilitation 1.11;

d. special care 3.11;

e. clinically complex 4.31;

f. clinically complex 4.21;

g. impaired cognition 5.21;

h. behavior problems 6.21;

i. reduced physical function 7.41; and

j. reduced physical function 7.31.

2. Monitored in-home caregiving services under tier 2 shall be available to the following resource utilization categories/scores as determined by the MDS-HC assessment:

a. extensive services 2.13;

b. extensive services 2.12;

c. extensive services 2.11; and

d. special care 3.12.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 40:792 (April 2014), amended LR 41:2642 (December 2015).

Chapter 85. Self-Direction Initiative

§8501. Self-Direction Service Option

A. The self-direction initiative is a voluntary, self-determination option which allows the participant to coordinate the delivery of personal assistance services through an individual direct support professional rather than through a licensed, enrolled provider agency. Selection of this option requires that the participant utilize a payment mechanism approved by the department to manage the required fiscal functions that are usually handled by a provider agency.

B. Participant Responsibilities. Waiver participants choosing the self-directed services option must understand the rights, risks, and responsibilities of managing their own care and individual budget. If the participant is unable to make decisions independently, he/she must have a responsible representative who understands the rights, risks, and responsibilities of managing his/her care and supports within his/her individual budget.

C. Termination of the Self-Direction Service Option. Termination of participation in the self-direction service option requires a revision of the POC, the elimination of the fiscal agent and the selection of the Medicaid-enrolled waiver service provider(s) of choice.

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

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

a. the health or welfare of the participant is compromised by continued participation in the self-directed option;

b. the participant 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 participant or the responsible representative; or

d. the participant or responsible representative:

i. places barriers to the payment of the salaries and related state and federal payroll taxes of direct support staff;

ii. fails to follow the POC;

iii. fails to provide required documentation of expenditures and related items;

iv. fails to cooperate with the fiscal agent or support coordinator in preparing any additional documentation of expenditures;

v. violates Medicaid Program rules or guidelines of the self-direction option; or

vi. fails to receive self-directed services for 90 days or more.

D. Employee Qualifications. All employees under the self-direction option must:

1. be at least 18 years of age on the date of hire; and

2. complete all training mandated by OAAS within the specified timelines.

E. A portion of the overall budget will be used to offset administrative costs for the fiscal management agency. After this portion has been deducted from the overall budget, the remainder will be the budget amount for the individual participant.

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 37:3523 (December 2011), amended LR 39:321 (February 2013), LR 39:1779 (July 2013).

Chapter 86. Organized Health Care Delivery System

§8601. General Provisions

A. An organized health care delivery system (OHCDS) is an entity with an identifiable component within its mission to provide services to individuals receiving Community Choices Waiver services. The entity must be a qualified and enrolled Medicaid provider and must directly render at least one service offered in the Community Choices Waiver. As long as the entity furnishes at least one waiver service itself, it may contract with other qualified providers to furnish the other required waiver services.

B. Entities that function as an OHCDS must ensure that subcontracted entities meet all of the applicable provider qualification standards for the services they are rendering.

C. The OHCDS must attest that all provider qualifications are met in accordance with all of the applicable waiver provider qualifications as set forth in the waiver document.

D. Prior to enrollment, an OHCDS must show the ability to provide all of the services available in the Community Choices Waiver on December 1, 2012, with the exceptions of support coordination, transition intensive support coordination, transition services and adult day health care if there is no licensed adult day health care provider in the service area.

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 40:792 (April 2014), amended LR 41:2643 (December 2015).

Chapter 87. Plan of Care

§8701. Plan of Care

A. The applicant and support coordinator have the flexibility to construct a plan of care that serves the participant's health and welfare needs. The service package provided under the POC shall include services covered under the community choices waiver in addition to services covered under the Medicaid state plan (not to exceed the established service limits for either waiver or state plan services) as well as other services, regardless of the funding source for these services. All services approved pursuant to the POC shall be medically necessary and provided in a cost-effective manner. The POC shall be developed using a person-centered process coordinated by the support coordinator.

B. Reimbursement shall not be made for community choices waiver services provided prior to the department's, or its designee's, approval of the POC.

C. The support coordinator shall complete a POC which shall contain the:

1. types and number of services (including waiver and all other services) necessary to reasonably assure health and welfare and to maintain the person in the community;

2. individual cost of each waiver service; and

3. the total cost of waiver services covered by the POC.

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 37:3524 (December 2011), amended LR 39:321 (February 2013).

Chapter 89. Admission and Discharge Criteria

§8901. Admission Criteria

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

1. meets the target population criteria as specified in the approved waiver document;

2. initial and continued Medicaid eligibility;

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

4. justification, as documented in the approved POC, that the community choices waiver services are appropriate, cost effective and represent the least restrictive environment for the individual; and

5. reasonable assurance that the health and welfare of the participant can be maintained in the community with the provision of community choices waiver services.

B. Failure of the individual to cooperate in the eligibility determination, plan of care development process or to meet any of the criteria above shall result in denial of admission to the community choices 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 37:3524 (December 2011), amended LR 39:322 (February 2013).

§8903. Admission Denial or Discharge Criteria

A. Admission shall be denied or the participant shall be discharged from the Community Choices Waiver Program if any of the following conditions are determined.

1. The individual does not meet the target population criteria as specified in the approved waiver document.

2. The individual does not meet the criteria for Medicaid eligibility.

3. The individual does not meet the criteria for a nursing facility level of care.

4. The participant resides in another state or has a change of residence to another state.

5. Continuity of services is interrupted as a result of the participant not receiving and/or refusing community choices waiver services (exclusive of support coordination services) for a period of 30 consecutive days.

6. The health and welfare of the individual cannot be reasonably assured through the provision of community choices waiver services.

7. The individual fails to cooperate in the eligibility determination or plan of care development processes or in the performance of the POC.

8. Failure on behalf of the individual to maintain a safe and legal environment.

9. It is not cost effective or appropriate to serve the individual in the community choices 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 37:3524 (December 2011), amended LR 39:322 (February 2013).

Chapter 93. Provider Responsibilities

§9301. General Provisions

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

B. The provider agrees to not request payment unless the participant for whom payment is requested is receiving services in accordance with the Community Choices Waiver Program provisions and the services have been prior authorized and actually provided.

C. Any provider of services under the community choices waiver shall not refuse to serve any individual who chooses their agency unless there is documentation to support an inability to meet the individual's health and welfare needs, or all previous efforts to provide service and supports have failed and there is no option but to refuse services.

1. OAAS or its designee must be immediately notified of the circumstances surrounding a refusal by a provider to render services.

2. This requirement can only be waived by OAAS or its designee.

D. Providers must maintain adequate documentation as specified by OAAS, or its designee, to support service delivery and compliance with the approved POC and will provide said documentation at the request of the department, or its designee.

E. Any provider of services under the community choices waiver shall not interfere with the eligibility, assessment, care plan development, or care plan monitoring processes with use of methods including, but not limited to:

1. harassment;

2. intimidation; or

3. threats against program participants or members of their informal support network, of DHH, or support coordination staff.

F. Any provider of services under the community choices waiver shall have the capacity and resources to provide all aspects of any service they are enrolled to provide in the specified service area.

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 37:3524 (December 2011), amended LR 39:322 (February 2013).

§9303. Reporting Requirements

A. Support coordinators and direct service providers are obligated to report, within specified time lines, any 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 are responsible for documenting the occurrence of incidents or accidents that affect the health and welfare of the participant and for completing an incident report. The incident report shall be submitted to the department or its designee with the specified requirements within specified time lines.

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 37:3525 (December 2011), amended LR 39:322 (February 2013).

Chapter 95. Reimbursement

§9501. Unit of Reimbursement

A. Reimbursement for the following services shall be a prospective flat rate for each approved unit of service provided to the participant. One quarter hour (15 minutes) is the standard unit of service, which covers both the service provision and administrative costs for the following services, and reimbursement shall not be made for less than one quarter hour (15 minutes) of service:

1. personal assistance services (except for the "a.m. and p.m." service delivery model);

a. up to three participants may share personal assistance services if they live together and share a common provider of these services; and

b. there is a separate reimbursement rate for shared personal care services;

2. in-home caregiver temporary support service when provided by a personal care services or home health agency;

3. caregiver temporary support services when provided by an adult day health care center;

4. adult day health care services;

5. housing transition or crisis intervention services; and

6. housing stabilization services.

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

1. environmental accessibility adaptations;

2. assistive devices and medical supplies;

3. home delivered meals (not to exceed the maximum limit set by OAAS);

4. transition expenses (not to exceed the maximum lifetime limit set by OAAS); and

5. the assessment performed by the monitored in-home caregiving provider.

C. The following services shall be reimbursed at a per diem rate:

1. caregiver temporary support services when rendered by the following providers:

a. assisted living providers;

b. nursing facility; or

c. respite center; and

2. monitored in-home caregiving services.

a. The per diem rate for monitored in-home caregiving services does not include payment for room and board, and federal financial participation is not claimed for room and board.

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

1. support coordination;

2. transition intensive support coordination; and

3. monthly monitoring/maintenance for certain assistive devices/technology and medical supplies procedures.

E. Non-medical transportation is reimbursed per one-way trip at a fee established by OAAS.

F. The following services shall be reimbursed on a per-visit basis:

1. certain nursing and skilled maintenance therapy procedures; and

2. personal assistance services furnished via “a.m. and p.m.” delivery method.

G. The following services shall be reimbursed on a per-visit basis:

1. certain environmental accessibility adaptations; and

2. certain nursing, and skilled maintenance therapy procedures.

H. Reimbursement shall not be made for community choices waiver services provided prior to the department’s approval of the POC and release of prior authorization for the 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 37:3525 (December 2011), amended LR 39:322 (February 2013), LR 39:508, 508 (March 2013), repromulgated LR 39:1048 (April 2013), amended LR 39:1779 (July 2013), LR 40:793 (April 2014), LR 42:897 (June 2016).