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 enhance the long term services and supports available to individuals with developmental disabilities. These individuals would otherwise require an intermediate care facility for persons with intellectual disabilities (ICF/ID) level of care.

B. The goal of the Residential Options Waiver is to promote independence through strengthening the individual's capacity for self-care, self-sufficiency and community integration utilizing a wide array of services, supports and residential options, which best meets the individual's needs and preferences, while supporting the dignity, quality of life, and security in the everyday life of the individual as he/she is a member of his/her 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).

§16103. Program Description

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

B. ROW offers an alternative to institutional care that:

1. utilizes a wide array of services, supports and residential options, which best meet the individual's needs and preferences;

2. meets the highest standards of quality and national best practices in the provision of services; and

3. ensures health and safety through a comprehensive system of participant safeguards.

C. All ROW services are accessed through the support coordination agency of the participant's choice.

1. The plan of care (POC) shall be developed using a person-centered process coordinated by the participant's support coordinator.

D. All services must be prior authorized and delivered in accordance with the approved POC.

E. The total expenditures available for each waiver participant is established through an assessment of individual support needs and may not exceed the approved ICF/ID ICAP rate/ROW budget level established for that individual except as approved by Office for Citizens with Developmental Disabilities' (OCDD's) assistant secretary,

deputy assistant secretary or his/her designee to prevent institutionalization.

1. When the department determines that it is necessary to adjust the ICF/ID ICAP rate, each waiver participant's annual service budget may be adjusted to ensure that the participant's total available expenditures do not exceed the approved ICAP rate.

F. No reimbursement for ROW services shall be made for a participant 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).

§16104. Settings for Home and Community Based Services

A. ROW participants 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 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, Subpart 1 or any subsequent 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).

§16105. Participant Qualifications

A. In order to qualify for Residential Options Waiver (ROW), individuals of all ages must meet all of the following criteria:

1. have an intellectual and/or developmental disability as specified in R.S. 28:451.2;

2. be determined eligible through the developmental disabilities entry process;

3. be on the intellectual/developmental disabilities (IDD) request for services registry (RFSR), unless otherwise specified through programmatic allocation in §16107;

4. meet the requirements for an ICF/ID level of care which requires active treatment for developmental disabilities under the supervision of a qualified developmental disabilities professional;

5. meet the financial eligibility requirements for the Louisiana Medicaid Program;

6. have justification, based on a uniform needs-based assessment and a person-centered planning discussion that the ROW is the OCDD waiver that will meet the needs of the individual;

7. be a resident of Louisiana; and

8. be a citizen of the United States or a qualified alien.

B. Individuals age 18 through 20 may be offered a funded ROW opportunity if the results of the uniform needs-based assessment and person-centered planning discussion determine that the ROW is the most appropriate waiver. These offers are subject to the approval of the OCDD assistant secretary/designee.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2441 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2155 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2530 (December 2017), LR 45:1764 (December 2019).

§16106. Money Follows the Person Rebalancing Demonstration

A. The Money Follows the Person (MFP) Rebalancing Demonstration is a federal demonstration grant awarded by the Centers for Medicare and Medicaid Services to the Department of Health and Hospitals. The MFP demonstration is a transition program that targets individuals using qualified institutional services and moves them to home and community-based long-term care services.

1. For the purposes of these provisions, a qualified institution is a nursing facility, hospital, or Medicaid enrolled intermediate care facility for people with intellectual disabilities (ICF/ID).

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

1. Participants with a developmental disability must:

a. occupy a licensed, approved Medicaid enrolled nursing facility, hospital or ICF/ID bed for at least three consecutive months; and

b. be Medicaid eligible, eligible for state developmental disability services, and meet an ICF/ID level of care.

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

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

D. All other ROW provisions apply to the Money Follows the Person Rebalancing Demonstration.

E. MFP participants 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).

§16107. Programmatic Allocation of Waiver Opportunities

A. The intellectual/developmental disabilities request for services registry, hereafter referred to as "the registry," shall be used to identify persons with intellectual and/or developmental disabilities who are waiting for an OCDD waiver opportunity. Individuals who are found eligible for developmental disabilities services using standardized tools, and who request waiver services will be added to the registry. The request for services registry (RFSR) is arranged by urgency of need and date of application for developmentally disabled (DD) waiver services, except for the priority groups listed in B.1-4 of this Section.

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

1. Individuals with intellectual and developmental disabilities (I/DD) who have a statement of approval (SOA) through OCDD, and who currently receive services via the Office of Aging and Adult Services (OAAS) Community Choices Waiver (CCW) or Adult Day Health Care (ADHC) Waiver programs, shall be a priority group to allow for an one time transition into the ROW upon promulgation of this final Rule.

2. Individuals living at Pinecrest Supports and Services Center or in a publicly operated ICF-ID when it was transitioned to a private ICF-ID through a cooperative endeavor agreement, or their alternates. Alternates are defined as individuals living in a private ICF-ID who will give up the private ICF-ID bed to an individual living at Pinecrest or to an individual who was living in a publicly operated ICF-ID when it was transitioned to a private ICF-ID through a cooperative endeavor agreement. Individuals requesting to transition from either facility listed above are awarded the appropriate waiver when one is requested, and their health and safety can be assured in an OCDD home and community-based waiver program.

3. Individuals on the registry who have the highest level of need and the earliest registry date shall be notified in writing when a funded OCDD waiver opportunity is available and that he/she is next in line to be evaluated for a possible waiver assignment. Participants shall have justification, based on a uniform needs-based assessment and a person-centered planning discussion that the ROW is the OCDD waiver that will meet the needs of the individual.

4. Persons who reside in a Medicaid-enrolled ICF/ID and wish to transition to a home and community-based residential services waiver through a voluntary ICF/ID bed conversion process.

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2441 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2155 (October 2015), LR 42:62 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2530 (December 2017), LR 45:1764 (December 2019).

§16109. Admission Denial or Discharge Criteria

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

1. The individual does not meet the financial eligibility requirements for the Medicaid Program.

2. The individual does not meet the requirements for an ICF/ID level of care.

3. The individual does not meet developmental disability system eligibility.

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

5. The individual resides in another state.

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

7. The individual fails to cooperate in the eligibility determination process or in the development of the POC.

8. The individual does not have justification, based on a uniform needs-based assessment and a person-centered planning discussion that the ROW is the OCDD waiver that will meet the needs of the individual.

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

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

2. loss of eligibility for an ICF/ID level of care;

3. loss of developmental disability system eligibility;

4. incarceration or placement under the jurisdiction of penal authorities, courts, or state juvenile authorities;

5. change of residence to another state;

6. admission to an ICF/ID or nursing facility with the intent to stay and not to return to waiver services;

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

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

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

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

i. the participant shall be discharged from the ROW if the treating physician documents that the institutional stay will exceed 90 days.

10. continuity of services is interrupted as a result of the participant 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).

Chapter 163. Covered Services

§16301. Assistive Technology and Specialized Medical Equipment and Supplies

A. Assistive technology and specialized medical equipment and supplies (AT/SMES) are equipment, devices, controls, appliances, supplies, and services which enable the participant to:

1. have life support;

2. address physical conditions;

3. increase ability to perform activities of daily living;

4. increase, maintain or improve ability to function more independently in the home and/or community; and

5. increase their ability to perceive, control, or communicate.

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

1. evaluation of participant needs;

2. customization of the equipment or device;

3. coordination of necessary therapies, interventions or services;

4. training or technical assistance on the use and maintenance of the equipment or device for the participant or, where appropriate, his/her family members, legal guardian or responsible representative;

5. training or technical assistance, when appropriate, for professionals or other service providers, employers, or other individuals who are substantially involved in the participant's major life functions;

6. all service contracts and warranties included in the purchase of the item by the manufacturer; and

7. equipment or device repair and replacement of batteries and other items that contribute to ongoing maintenance of the equipment or device.

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

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 participant.

1. Items reimbursed in the ROW may be in addition to any medical equipment and supplies furnished under the Medicaid State Plan.

D. All assistive technology items must meet applicable manufacture, design and installation requirements.

E. Service Exclusions

1. Assistive technology devices and specialized equipment and supplies that are of general utility or maintenance and have no direct medical or remedial benefit to the participant are excluded from coverage.

2. Any equipment, device, appliance or supply that is covered and has been approved under the Medicaid State Plan, Medicare, or any other third party insurance is excluded from coverage.

3. For adults over the age of 20 years, specialized chairs, whether mobile or travel, are not covered.

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

1. be enrolled in the Medicaid Program as a assistive devices or durable medical equipment provider and must meet all of the applicable vendor standards and requirements for manufacturing, design and installation of technological equipment and supplies;

2. furnish written documentation of authorization to sell, install, and/or repair technological equipment and supplies from the respective manufacturer of the designated equipment and supplies; and

3. provide documentation of individual employees' training and experience with the application, use, fitting, and

repair of the equipment or devices which they propose to sell or repair;

a. upon completion of the work and prior to payment, the provider shall give the participant 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).

§16303. Community Living Supports

A. Community living supports (CLS) are services provided to assist participants to achieve and maintain the outcomes of increased independence, productivity and inclusion in the community by utilizing teaching and support strategies. CLS may be furnished through self-direction or through a licensed, enrolled agency.

B. Community Living Supports are related to acquiring, retaining and improving independence, autonomy and adaptive skills. CLS may include the following services:

1. direct support services or self-help skills training for the performance of all the activities of daily living and self-care;

2. socialization skills training;

3. cognitive, communication tasks, and adaptive skills training; and

4. development of appropriate, positive behaviors.

C. Place of Service. CLS services are furnished to adults and children who live in a home that is leased or owned by the participant or his 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 participants who may or may not live together, and who have a common direct service provider. 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 participants, or their legal guardians, regarding the provisions of shared CLS services.

2. The health and welfare of each participant must be assured though the provision of shared services.

3. Services must be reflected in each participant's approved plan of care and based on an individual-by-individual determination.

4. A shared rate must be billed.

E. Service Exclusions

1. Staff providing services may not sleep during billable hours of Community Living Supports.

2. Routine care and supervision that is normally provided by the participant's spouse or family, and services provided to a minor by the child's parent or step-parent, are not covered.

3. CLS services may not be furnished in a home that is not leased or owned by the participant or the participant's family.

4. Participants may not live in the same house as CLS staff.

5. Room and board or maintenance, upkeep and improvement of the individual's or family's residence is not covered.

6. Community living supports shall not be provided in a licensed respite care facility.

7. Community living supports services are not available to individuals receiving the following services:

a. shared living;

b. host home;

c. companion care; or

d. monitored in-home caregiving.

8. Community living supports cannot be billed or provided for during the same hours on the same day that the participant is receiving the following services:

a. day habilitation;

b. prevocational;

c. supported employment;

d. respite out-of-home services;

e. transportation-community access;

f. monitored in-home caregiving; or

g. adult day health care.

F. Provider Qualifications. CLS providers must possess a current, valid license as a Personal Care Attendant Agency.

1. Family members who provide CLS services must meet the same standards as providers who are unrelated to the 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, 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).

§16305. Companion Care

A. Companion care services assist the participant to achieve and/or maintain the outcomes of increased independence, productivity and inclusion in the community. These services are designed for individuals who live independently and can manage their own household with limited supports. The companion provides services in the participant's home and lives with the participant as a roommate. Companion care services may be furnished through self-direction or through a licensed provider organization as outlined in the participant's POC. This service includes:

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

2. community integration and coordination of transportation services, including medical appointments.

B. Companion care services can be arranged by licensed providers who hire companions, or services can be self-directed by the participant. The companion is a principal care provider who is at least 18 years of age, who lives with the participant as a roommate, and provides services in the participant's home.

C. Provider Responsibilities

1. The provider organization shall develop a written agreement as part of the participant's POC which defines all of the shared responsibilities between the companion and the participant. The written agreement shall include, but is not limited to:

a. types of support provided by the companion;

b. activities provided by the companion; and

c. a typical weekly schedule.

2. Revisions to this agreement must be facilitated by the provider and approved by the support team. Revisions may occur at the request of the participant, the companion, the provider or other support team members.

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

a. arranging the delivery of services and providing emergency services as needed;

b. making an initial home inspection of the participant's 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 participant's POC; and

d. providing 24-hour oversight and supervision of the companion care services, including back-up for the scheduled and unscheduled absences of the companion.

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

D. Companion Responsibilities

1. The companion is responsible for:

a. participating in and abiding by the POC;

b. maintaining records in accordance with State and provider requirements; and

c. purchasing his/her own food and personal care items.

E. Service Limits

1. The provider agency must provide relief staff for scheduled and unscheduled absences, available for up to 360 hours (15 days) as authorized by the POC. Relief staff for scheduled and unscheduled absences is included in the provider agency's rate.

F. Service Exclusions

1. Companion care is not available to individuals receiving the following services:

a. respite care service–out of home;

b. shared living;

c. community living supports;

d. host home; or

e. monitored in-home caregiving.

G. Provider Qualifications. The provider agency must be licensed as a personal care attendant agency.

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).

§16307. Day Habilitation Services

A. Day habilitation services are aimed at developing activities and/or skills acquisition to support or further community integration opportunities outside of an individual's home. These activities shall promote independence, autonomy and assist the participant with developing a full life in his community. The primary focus of day habilitation services is acquisition of new skills or maintenance of existing skills based on individualized preferences and goals.

1. The skill acquisition and maintenance activities should include formal strategies for teaching the individualized skills and include the intended outcome for the participant.

2. Individualized progress for the skill acquisition and maintenance activities should be routinely reviewed and evaluated, with revisions made as necessary to promote continued skill acquisition.

3. As an individual develops new skills, training should progress along a continuum of habilitation services offered toward greater independence and self-reliance.

B. Day habilitation services shall:

1. focus on enabling participants to attain maximum skills;

2. be coordinated with any physical, occupational or speech therapies listed in the participant's POC;

3. serve to reinforce skills or lessons taught in school, therapy or other settings; and

4. be furnished on a regularly scheduled basis for 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 participant;

b. services shall not exceed 32 units of service on any given day or 160 units in any given week in a plan of care;

c. any time less than the 15 minute unit of service is not billable or payable; and

d. no rounding up of hours is allowed.

C. The provider is responsible for all transportation from the agency to all work sites related to the provision of service.

1. Transportation to and from the service site is offered and billable as a component of the day habilitation service; however, transportation is payable only when a day habilitation service is provided on the same day.

D. Participants may receive more than one type of vocational/habilitative service per day as long as the service and billing criteria are followed and as long as requirements for the minimum time spent on site are adhered to.

E. Service Exclusions

1. Time spent traveling to and from the day habilitation program site shall not be included in the calculation of the total number of day habilitation service hours provided per day.

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

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

3. Day habilitation services cannot be billed or provided during the same hours on the same day as any of the following services:

a. community living supports;

b. professional services, except those direct contacts needed to develop a behavioral management plan or any other type of specialized assessment/plan;

c. respite care services—out of home;

d. adult day health care; or

e. monitored in-home caregiving.

F. Provider Qualifications. Providers must be licensed as an adult day care agency.

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).

§16309. Dental Services

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

1. diagnostic services (radiographs, complete series including bitewing);

2. preventative services (comprehensive oral examination, new patient or periodic oral examination patient of record); and

3. prophylaxis-adult (cleanings).

B. Service Exclusion. Participants must first access dental services covered under the Medicaid State Plan before utilizing dental services through the Residential Options Waiver.

C. Provider Qualifications. Providers must have a current, valid license to provide dental services from the Louisiana State Board of Examiners for Dentistry for the specific dental services in all specialty areas provided to the 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, 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).

§16311. Environmental Accessibility Adaptations

A. Environmental accessibility adaptations are physical adaptations to the participant's home or vehicle which must be specified in the POC as necessary to enable the participant to integrate more fully into the community and to ensure his/her health, welfare and safety.

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

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

1. assessments to determine the types of modifications that are needed;

2. training the participant and appropriate direct care staff in the use and maintenance of devices, controls, appliances and related items;

3. repair of all equipment and/or devices, including replacement of batteries and other items that contribute to the ongoing maintenance of the adaptation(s); and

4. all service contracts and warranties which the manufacturer includes in the purchase of the item.

C. In order to accommodate the medical equipment and supplies necessary to assure the welfare of the participant, home accessibility adaptations may include the following:

1. installation of ramps and grab-bars;

2. widening of doorways;

3. modification of bathroom facilities; or

4. installation of specialized electric and plumbing systems.

D. Home accessibility adaptations may be applied to rental or leased property only under the following conditions:

1. the participant is renting or leasing the property; and

2. written approval is obtained from the landlord and OCDD.

E. When state and local building or housing code standards are applicable, modifications to the home shall meet such standards.

F. Service Exclusions for Home Adaptations

1. Home modification funds are not intended to cover basic construction cost. Waiver funds may only be used to pay the cost of purchasing specific approved adaptations for the home, not for the construction costs of additions to the home.

2. Home modifications shall not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

3. Home modifications shall not include those modifications which add to the total square footage of the home, except when the additional square footage is necessary to make the required adaptation work.

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

a. flooring;

b. roof repair;

c. central air conditioning;

d. hot tubs;

e. swimming pools;

f. exterior fencing; or

g. general home repair and maintenance.

G. Vehicle adaptations are modifications to an automobile or van that is the waiver participant's primary means of transportation in order to accommodate his/her special needs.

1. The modifications may include the installation of a lift or other adaptations to make the vehicle accessible to the participant or for him/her to drive.

H. Service Exclusions for Vehicle Adaptations

1. Payment will not be made to:

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

b. to purchase or lease a vehicle.

2. Vehicle modifications which are of general utility and are not of direct medical or remedial benefit to the participant are not covered in the ROW.

3. Regularly scheduled upkeep and maintenance of a vehicle is not covered.

4. Car seats are not considered a vehicle adaptation.

I. Provider Responsibilities

1. The environmental accessibility adaptation(s) must be delivered, installed, operational and reimbursed in the POC year in which it was approved.

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

3. Vehicle modifications must meet all of the applicable standards of manufacture, design and installation for all adaptations to the vehicle.

4. Upon completion of the work and prior to payment, the provider shall give the participant a certificate of warranty for all labor and installation and all warranty certificates from manufacturers.

J. Provider Qualifications. In order to participate in the Medicaid Program, providers must meet the following qualifications.

1. Providers of environmental accessibility adaptations for the home must be registered through the Louisiana State Licensing Board for Contractors as a home improvement contractor.

a. In addition, these providers must:

i. meet the applicable state and/or local requirements governing their licensure or certification; and

ii. comply with the applicable state and local building or housing code standards governing home modifications.

b. The individuals performing the actual service (building contractors, plumbers, electricians, carpenters, etc.) must also comply with the applicable state and/or local requirements governing individual licensure or certification.

2. Providers of environmental accessibility adaptations to vehicles must be licensed by the Louisiana Motor Vehicle Commission as a specialty vehicle dealer and accredited by the National Mobility Equipment Dealers Association under the Structural Vehicle Modifier category.

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).

§16313. Host Home

A. Host home services assist participants in meeting their basic adaptive living needs and offer direct support where required. Participants are afforded a welcoming, safe and nurturing family atmosphere in a family home environment in which the participant may receive supports, services and training in accordance with the POC. Host home services take into account compatibility, including individual interests, age, needs for privacy, supervision and support needs. These services are provided in a private home by a contractor of the host home agency who lives in the home, and either rents or owns the residence. The contractor utilizes specific teaching strategies to encourage independence and autonomy when required as a part of the participant's POC.

B. Host home services include:

1. assistance with the activities of daily living and adaptive living needs;

2. assistance to develop leisure interests and daily activities in the home setting;

3. assistance to develop relationships with other members of the household;

4. supports in accessing community services, activities and pursuing and developing recreational and social interests outside the home; and

5. teaching community living skills to achieve participant's goals concerning community and social life as well as to maintain contacts with biological families and natural supports.

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

1. arranging for a host home;

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 participant; and

3. providing 24-hour oversight and supervision of host home services including emergency services and back-up for the scheduled and nonscheduled absences of the contractor.

D. Host home contractors are responsible for:

1. assisting with the development of the participant's POC and complying with the provisions of the plan;

2. maintaining and providing data to assist in the evaluation of the participant's personal goals;

3. maintaining adequate records to substantiate service delivery and producing such records upon request;

4. undergoing any specialized training deemed necessary by the provider agency, or required by the department, to provide supports in the host home setting; and

5. immediately reporting to the department and applicable authorities any major issues or concerns related to the participant's safety and well-being.

E. Host home contractors who serve children are required to provide daily supports and supervision on a 24-hour basis to meet on-going support needs and to handle emergencies as any family would do for their minor child as required and based on age, capabilities, health conditions and any special needs.

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

1. Host home contractors that serve adults who have been interdicted must ensure that services are furnished in accordance with the legal requirements of the interdiction.

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 participant.

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

I. Service Exclusions

1. Separate payment will not be made for community living supports since these services are integral to, and inherent in, the provision of host home services.

2. Separate payment will not be made for the following residential service models if the participant is receiving host home services:

a. respite care services-out of home;

b. shared living;

c. shared living-conversion;

d. companion care; or

e. monitored in-home caregiving.

3. The host home contractor may not be the same individual as the owner or administrator of the designated provider agency.

J. Provider Qualifications

1. All agencies must:

a. have experience in delivering therapeutic services to persons with developmental disabilities;

b. have staff who have experience working with persons with developmental disabilities;

c. screen, train, oversee and provide technical assistance to the host home contractors in accordance with OCDD requirements, including the coordination of an array of medical, behavioral and other professional services appropriate for persons with developmental disabilities; and

d. provide on-going assistance to the host home contractors so that all HCBS requirements are met.

2. Agencies serving children must be licensed by the Department of Children and Family Services as a Class "A" Child Placing Agency.

3. Agencies serving adults must be licensed by the Department of Health as a provider of substitute family 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, 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).

§16317. Nursing Services

A. Nursing services are medically necessary services ordered by a physician and provided by a licensed registered nurse or a licensed practical nurse within the scope of the State's Nurse Practice Act. Nursing services provided in the ROW are an extension of nursing services provided through the Home Health Program covered under the Medicaid State Plan.

1. These services require an individual nursing service plan and must be included in the plan of care.

2. The nurse must submit updates of any changes to the individual's needs and/or the physician's orders to the support coordinator every 60 days.

B. Nursing consulting services include assessments and health related training and education for participants and caregivers.

1. Assessment services are offered on an individual basis only and must be performed by a registered nurse.

2. Consulting services may also address healthcare needs related to prevention and primary care activities.

3. The health related training and education service is the only nursing service which can be provided to more than one participant simultaneously. The cost of the service is allocated equally among all participants.

C. Service Requirement. Participants over the age of 21 years must first exhaust all available nursing visits provided under the Medicaid State Plan prior to receiving services through the waiver program.

D. Provider Qualifications

1. In order to participate in the Medicaid Program, the provider agency must possess a current, valid license as a home health agency or, if under the ROW shared living conversion model, be an enrolled shared living services agency with a current, valid license as a supervised independent living agency.

E. Staffing Requirements

1. Nursing services shall be provided by individuals with either a current, valid license as a registered nurse from the Louisiana State Board of Nursing or a current, valid license as a practical nurse from the Board of Practical Nurse Examiners.

2. The RN or the LPN must possess one year of service delivery experience to persons with intellectual disabilities defined under the following criteria:

a. full-time experience gained in advanced and accredited training programs (i.e. masters or residency level training programs), which includes treatment services for persons with developmental disabilities;

b. paid, full-time nursing experience in specialized service/treatment settings for persons with developmental disabilities (i.e. intermediate care facilities for persons with developmental disabilities;

c. paid, full-time nursing experience in multi-disciplinary programs for persons with developmental disabilities (i.e. mental health treatment programs for persons with dual diagnosis, mental illness and developmental disabilities); or

d. paid, full-time nursing experience in specialized educational, vocational and therapeutic programs or settings for persons with developmental disabilities (i.e. school special education program).

3. Two years of part-time experience with a minimum of 20 hours per week may be substituted for one year of full-time experience.

4. The following activities do not qualify for the required experience:

a. volunteer nursing experience; or

b. experience gained by caring for a relative or friend with developmental disabilities.

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).

§16319. One Time Transitional Services

A. One-time transitional services are one-time, set-up services to assist individuals in making the transition from an institution to their own home or apartment in the community of their choice.

B. Allowable transitional expenses may include:

1. nonrefundable security deposits that do not include rental payments;

2. set up fees for utilities;

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

a. bedroom and living room furniture;

b. table and chairs;

c. window blinds; and

d. food preparation items and eating utensils;

4. set-up/deposit fee for telephone service;

5. moving expenses; and

6. health and safety assurances including:

a. pest eradication; or

b. one-time cleaning prior to occupancy.

C. Service Limits

1. One-time transitional expenses are capped at $3,000 per person over a participant's lifetime.

D. Service Exclusions

1. One-time transitional services may not be used to pay for:

a. housing, rent or refundable security deposits; or

b. furnishings or setting up living arrangements that are owned or leased by a waiver provider.

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

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

E. The Office for Citizens with Developmental Disabilities shall be the entity responsible for coordinating the delivery of one time transitional services.

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

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

§16321. Personal Emergency Response System (PERS)

A. Personal emergency response system (PERS) is a system connected to the participant's telephone that incorporates an electronic device which enables the participant to secure help in an emergency. The device can be worn as a portable "help" button and when activated, a response center is contacted.

B. Participant Qualifications. PERS services are available to individuals who:

1. have a demonstrated need for quick emergency back-up;

2. are unable to use other communication systems due to experiencing difficulty in summoning emergency assistance; or

3. do not have 24-hour direct supervision.

C. PERS services include rental of the electronic device, initial installation, training the participant to use the equipment, and monthly maintenance fees.

D. Service Exclusions

1. Separate payment will not be made for shared living services.

E. Provider Qualifications

1. The provider must be authorized by the manufacturer to install and maintain equipment for personal emergency response systems.

2. The provider shall be in compliance with all applicable federal, state, and local regulations governing the operation of personal emergency response systems including staffing requirements for the response center.

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).

§16323. Prevocational Services

A. Prevocational services are time limited with employment at the individual's highest level of work in the most integrated community setting, with the job matched to the individual's interests, strengths, priorities, abilities and capabilities, with integrated competitive employment as the optimal outcome. Individuals receiving prevocational services may choose to pursue employment opportunities at

any time. Career planning must be a major component of prevocational services.

B. 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 be focused on preparing the participant for paid employment or a volunteer opportunity in the community. These services are operated through a provider agency that is licensed by the appropriate state licensing agency. Services are furnished one or more hours per day on a regularly scheduled basis for one or more days per week.

C. Participants receiving services must have an employment related goal in their plan of care, and the general habilitation activities must be designed to support such employment goals. Prevocational services are designed to create a path to integrated community-based employment for which a participant 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.

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

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

F. Service Limitations

1. Services shall not exceed 8,320 units of service in a plan of care.

2. Prevocational services are not available to participants who are eligible to participate in programs funded under the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.

3. Multiple vocational/habilitative services cannot be provided or billed for during the same hours on the same day as the following services:

a. community living supports;

b. professional services, except those direct contacts needed to develop a behavioral management plan or other type of specialized assessment/plan;

c. respite care services–out of home;

d. adult day healthcare; or

e. monitored-in–home caregiving.

4. Transportation to and from the service site is only payable when a vocational/habilitative service is provided on the same day.

a. Time spent in traveling to and from the prevocational program site shall not be included in the calculation of the total number of service hours provided per day.

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 shall not be used to transport ROW participants to any prevocational services

G. Restrictions

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

H. There must be documentation in the participant's file that this service is not 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 [230 U.S.C. 1401 (16 and 71)] and those covered under the state plan.

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).

§16325. Professional Services

A. Professional services are direct services to participants, based on need, that that may be utilized to increase the individual's independence, participation and productivity in the home, work and community. Service intensity, frequency and duration will be determined by individual need. Professional services must be delivered with the participant present and in accordance with approved POC.

B. Professional services include the services provided by the following licensed professionals:

1. occupational therapists;

2. physical therapists;

3. speech therapists;

4. registered dieticians;

5. social workers; and

6. psychologists.

C. Professional services may be utilized to:

1. perform assessments and/or re-assessments specific to professional disciplines to accomplish the desired outcomes for the participant and to provide recommendations, treatment, and follow-up;

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

3. intervene in and stabilize a crisis situation (behavioral or medical) that could result in the loss of home and community-based services, including the development, implementation, monitoring, and modification of behavioral support plans;

4. provide consultative services and recommendations;

5. provide necessary information to the participant, family, caregivers, and/or team to assist in planning and implementing services or treatment;

6. provide caregiver counseling for the participant's natural, adoptive, foster, or host family members in order to develop and maintain healthy, stable relationships among all caregivers, including family members, to support meeting the needs of the participant;

a. emphasis is placed on the acquisition of coping skills by building upon family strengths; and

b. services are intended to maximize the emotional and social adjustment and well-being of the individual, family, and caregiver; and

7. provide nutritional services, including dietary evaluation and consultation with individuals or their care provider.

a. Services are intended to maximize the individual's nutritional health.

NOTE: Psychologists and social workers will provide supports and services consistent with person-centered practices and *Guidelines for Support Planning*.

D. Service Exclusions

1. Professional services may only be furnished and reimbursed through ROW when the services are medically necessary, or have habilitative or remedial benefit to the participant.

2. Participants who are participating in ROW and are up to the age of 21 must access these services through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

E. Provider Qualifications

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

a. have a current, valid license from the appropriate governing board of Louisiana for that profession; and

b. possess one year of service delivery experience with persons with developmental disabilities.

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

2. Provider agency enrollment of professional services.

a. The following provider agencies may enroll to provide professional services:

i. a Medicare certified free-standing rehabilitation center;

ii. a licensed home health agency;

iii. a supervised independent living agency licensed by the department to provide shared living services; or

iv. a substitute family care agency licensed by the department to provide host home services.

b. Enrolled provider agencies may provide professional services by one of the following methods:

i. employing the professionals; or

ii. contracting with the professionals.

c. Provider agencies are required to verify that all professionals employed by or contracted with their agency meet the same qualifications required for individual practitioners as stated in §16325.E.1.a-c.

3. All professionals delivering professional services must meet the required one year of service delivery experience as defined by the following:

a. full-time experience gained in advanced and accredited training programs (i.e. master's or residency level training programs), which includes treatment services for persons with developmental disabilities;

b. paid, full-time experience in specialized service/treatment settings for persons with developmental disabilities (i.e. ICFs/ID);

c. paid, full-time experience multi-disciplinary programs for persons with developmental disabilities (i.e. mental health treatment programs for persons with dual diagnosis – mental illness and developmental disability); or

d. paid, full-time experience in specialized educational, vocational, and therapeutic programs or settings for persons with developmental disabilities (i.e. school special education program).

e. Two years of part-time experience with a minimum of 20 hours per week of the qualifying work experience activities may be substituted for one year of full-time experience.

4. The following activities do not qualify for the professional's required service delivery experience:

a. volunteer experience; or

b. experience gained by caring for a relative or friend with developmental disabilities.

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).

§16327. Respite Care Services–Out of Home

A. Respite care services–out of home are supports and services provided for the relief of those unpaid caregivers who normally provide care to participants who are unable to care for themselves. These services are furnished on a short-term basis in a licensed respite center.

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

a. The rate for respite care services–out of home includes the transportation costs for the community activities.

2. While receiving respite care services, the participant's routine is maintained in order to attend school, school activities or other community activities he/she would typically participate in if not in the center-based respite facility.

B. Service Limits

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

2. Requests for an extension of the service limit are subject to the department's established approval process and require proper justification and documentation.

C. Service Exclusions

1. Room and board shall be covered only if it is provided as part of respite care furnished in a state-approved facility that is not a private residence.

2. Respite care services-out of home may not be billed for participants receiving the following services:

a. shared living;

b. companion care;

c. host home; or

d. monitored in-home caregiving.

D. Provider Qualifications. The provider must possess a current, valid license as a respite care center 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, 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).

§16329. Shared Living Services

A. Shared living services assist the participant in acquiring, retaining and improving the self-care, adaptive and leisure skills needed to reside successfully in a shared home setting within the community. Services are chosen by the participant 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. 24-hour staff availability;

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

c. a daily schedule;

d. health and welfare needs;

e. transportation;

f. any non-residential ROW services delivered by the shared living services provider; and

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

B. An ICF/ID may elect to permanently relinquish its ICF/ID license and all of its Medicaid Facility Need Review approved beds from the total number of Certificate of Need (CON) beds for that home and convert it into a shared living waiver home or in combination with other ROW residential options as deemed appropriate in the approved conversion agreement.

1. In order to convert, provider request must be approved by the department and by OCDD.

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

3. If choosing ROW services, persons may select any ROW services and provider(s) based upon freedom of choice.

C. Shared Living Options

1. Shared Living Conversion Option. The shared living conversion option is only allowed for providers of homes which were previously licensed and Medicaid certified as an ICF/ID for up to a maximum of eight licensed and Medicaid-funded beds on October 1, 2009.

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

b. The ICF/ID used for the shared living conversion option must meet the department's operational, programming and quality assurances of health and safety for all participants.

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

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

2. Shared Living Non-Conversion (New) Option. The shared living non-conversion option is allowed only for new or existing ICF/ID providers to establish a shared living waiver home for up to a maximum of three individuals.

a. The shared living waiver home must be located separate and apart from any ICF/ID.

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

c. The shared living waiver home must meet department's operational, programming and quality assurances for home and community-based services.

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

D. Service Exclusions

1. Payments are not made for room and board, the cost of home maintenance, upkeep or improvements.

2. Payments shall not be made for environmental accessibility adaptations when the provider owns or leases the residence.

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

4. MFP participants 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 participants receiving shared living services, as this is a component of shared living services.

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

a. community living supports;

b. respite care services;

c. companion care;

d. host home;

e. personal emergency response system; or

f. monitored in-home caregiving.

E. Provider Qualifications. Providers must be approved by the department and have a current, valid license as a supervised independent living agency.

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).

§16333. Support Coordination

A. Support coordination services are provided to all ROW participants to assist them in gaining access to needed waiver services, as well as needed medical, social, educational and other services, regardless of the funding source for the services. Support coordination will provide information and assistance to waiver participants by directing and managing their services in compliance with the rules and regulations governing case management services.

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

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

B. Support coordinators are responsible for providing assistance to participants who choose the self-direction option with their review of the *Self-Direction Employer Handbook* and for being available to these participants for on-going support and help with carrying out their employer responsibilities.

C. Provider Qualifications. Providers must have a current, valid license as a case management agency and meet all other requirements for targeted case management services as set forth in LAC 50:XV.Chapter 105 and the *Medicaid Targeted Case Management Manual*.

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).

§16335. Supported Employment

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

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

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

2. job assessment, discovery and development; and

3. initial job support and job retention, including 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 participants 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. Transportation is included in supported employment services, but whenever possible, family, neighbors, friends, coworkers or community resources that can provide needed transportation without charge should be utilized.

E. These services are also available to those participants 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. the services furnished are not part of the normal duties of the coworker or other job-site personnel; and

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

G. Service Limits. Participants may receive more than one vocational or habilitative service per day as long as the service and billing requirements for each service are met.

1. Services for individual/micro-enterprise job assessment, discovery and development in individual jobs and self-employment shall not exceed 2,880 units of service in a plan of care year.

2. Services for group job assessment, discovery and development in group employment shall not exceed 480 units of service in a plan of care year.

3. Services for initial job support, job retention and follow-along for individual/micro-enterprise shall not exceed 1280 quarter hour units of service in a plan of care year.

4. Services for initial job support, job retention and follow-along in group employment shall not exceed 8,320 quarter hour units of service in a plan of care year.

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

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

2. Any time less than one hour for individual placement and micro-enterprise is not billable or payable.

3. Supported employment services cannot be billed for the same time as any of the following services:

a. community living supports;

b. professional services except direct contacts needed to develop a behavioral management plan; or

c. respite care services–out of home,;

d. adult day health care; or

e. monitored in-home caregiving.

4. Any time less than fifteen minutes for enclaves and mobile crews is not billable or payable.

5. Time spent in traveling to and from the prevocational program site shall not be included in the calculation of the total number of service hours provided per day.

a. Travel training for the purpose of teaching the participant 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.

6. The following incentive payments, subsidies or unrelated vocational training expenses are excluded from coverage in supported employment services:

a. incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

b. payments that are passed through to users of supported employment programs; or

c. payments for vocational training that is not directly related to an individual's supported employment program.

7. There must be documentation in the participant’s file that these services are not available from programs funded under the Rehabilitation Act of 1973 or sections 602 (16) or (17) of the Individuals with Disabilities Education Act [230 U.S.C. 1401 (16 and 17)] and those covered under the State Plan.

8. No rounding up of service units is allowed.

I. Provider Qualifications. In order to enroll in the Medicaid Program, providers must have a compliance certificate from the Louisiana Rehabilitation Services as a

community rehabilitation program or a current, valid license as an adult day care center.

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).

§16337. Transportation-Community Access

A. Transportation-community access services enable participants to gain access to waiver and other community services, activities and resources. These services are necessary to increase independence, productivity, community inclusion and to support self-directed employees benefits as outlined in the participant's POC. Transportation-community access shall be offered as documented in the participant's approved POC.

1. The participant must be present to receive this service.

2. Whenever possible, the participant must utilize the following resources for transportation:

a. family, neighbors, friends or community agencies which can provide this service without charge; or

b. public transportation or the most cost-effective method of transport available.

B. Service Limits

1. Community access trips are limited to three per day and must be arranged for geographic efficiency.

2. Greater than three trips per day require approval from the department or its designee.

C. Service Exclusions

1. Transportation services offered through ROW shall not replace the medical transportation services covered under the Medicaid State Plan or transportation services provided as a means to get to and from school.

2. Separate payment will not be made for transportation-community access and the following services:

a. shared living services;

b. community living services;

c. companion care;

d. adult day health care; or

e. monitored in-home caregiving.

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

D. Provider Qualifications. Friends and family members who furnish transportation-community access services to waiver participants must be enrolled as Medicaid friends and family transportation providers.

1. In order to receive reimbursement for transporting Medicaid recipients to waiver services, family and friends must maintain:

a. the state minimum automobile liability insurance coverage;

b. a current state inspection sticker; and

c. a current valid driver's license.

2. No special inspection by the Medicaid agency will be conducted.

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

a. The statement must also have the signature of two witnesses.

4. Family and friends transportation providers are limited to transporting up to three specific waiver participants.

E. Vehicle Requirements. All vehicles utilized by for profit and non-profit transportation services providers for transporting waiver participants 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).

§16339. Housing Stabilization Transition Services

A. Housing stabilization transition services enable participants 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 participant is in an institution and preparing to exit the institution using the waiver. Housing stabilization transition services include:

1. conducting a housing assessment to identify the participant'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;

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, including:

a. arranging or providing transportation;

b. assisting in securing supporting documents/records;

c. completing/submitting applications;

d. securing deposits; and

e. 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; and

5. exploring alternatives to housing if permanent supportive housing is unavailable to support completion of transition.

B. This service is only available upon referral from the support coordinator, and is not duplicative of other waiver services, including support coordination. It is only available to persons who reside in a state of Louisiana permanent supportive housing unit, or who are linked for the state of Louisiana permanent supportive housing selection process.

C. Participants may not exceed 165 combined units of this service and the housing stabilization service without written approval from OCDD.

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).

§16341. 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. Housing stabilization services include the following components:

1. conducting a housing assessment to identify the participant'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;

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

3. developing an individualized housing stabilization service provider 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. providing supports and interventions according to the individualized housing support 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);

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

a. the participant's disability;

b. accommodations needed; and

c. 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 participant's situation or status; and

7. if at any time the participant's housing is placed at risk (i.e., 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. Housing stabilization is not duplicative of other waiver services, including support coordination. It is only available to persons who reside in a state of Louisiana permanent supportive housing unit.

C. Participants may not exceed 165 combined units of this service and the housing stabilization transition service without written approval from OCDD.

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).

§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 health, medical, and social services needed to ensure the optimal functioning of the participant.

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

1. medical care management;

2. transportation between the participant's place of residence and the ADHC (if the participant is accompanied by the ADHC staff);

3. assistance with activities of daily living;

4. health and nutrition counseling;

5. an individualized exercise program;

6. an individualized goal-directed recreation program;

7. health education;

8. individualized health/nursing services; and

9. meals.

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

C. The number of participants included in the service per day shall be determined by the facility’s licensed capacity and attendance. The average capacity per facility is 49 participants.

D. Nurses shall be involved in the participant’s service delivery as specified in the POC or as needed. The ADHC shall develop an individualized service plan based on the participant’s POC. If the individualized service plan requires certain health and nursing services, the nurse on staff shall ensure that the services are delivered while the participant is at the ADHC facility.

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

F. The following services are not available to AFDC recipients:

1. respite care services-out of home;

2. shared living;

3. companion care, or

4. monitored in-home caregiving.

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).

§16345. 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 Residential Options Waiver services during the period of time that the participant is receiving monitored in-home caregiving services:

1. community living supports;

2. companion care;

3. host home;

4. shared living (conversion or non-conversion); or

5. adult day health care 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 LDH HIPAA business associate addendum.

G. The department shall reimburse for monitored in-home caregiving services based upon a two-tiered model which is designed to address the participant's ROW acuity level.

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).

Chapter 165. Self-Direction Initiative

§16501. Self-Direction Service Option

A. The self-direction initiative is a voluntary, self-determination option which allows the waiver participant to coordinate the delivery of designated ROW 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-direction service 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 must have an authorized representative who understands the rights, risks and responsibilities of managing his care and supports within his individual budget. Responsibilities of the participant or authorized representative include:

1. completion of mandatory trainings, including the rights and responsibilities of managing his own services and supports and individual budget;

2. participation in the self-direction service option without a lapse in, or decline in quality of care or an increased risk to health and welfare; and

a. participants must adhere to the health and welfare safeguards identified by the support team, including:

i. the application of a comprehensive monitoring strategy and risk assessment and management systems; and

ii. compliance with the requirement that employees under this option must have criminal background checks prior to working with waiver participants;

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 participant's POC to meet his needs.

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

C. Termination of 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. The 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 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-direction service option;

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

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

d. over three payment cycles in the period of a year, the participant or authorized 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 personal purchasing plan and the POC;

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

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

D. Employees of participants in the self-direction service option are not employees of the fiscal agent or the Department of Health and Hospitals.

E. 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 participant 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).

Chapter 167. Provider Participation

§16701. General Provisions

A. In order to participate in the Medicaid Program as a provider of services in the Residential Options Waiver, a provider must:

1. meet all of the requirements for licensure and the standards for participation in the Medicaid Program as a home and community-based services provider in accordance with state laws and the rules promulgated by the department;

2. comply with the regulations and requirements specified in LAC 50:XXI, Subparts 1 and 13 and the ROW provider manual;

3. comply with all of the state laws and regulations for conducting business in Louisiana, and when applicable, with the state requirements for designation as a non-profit organization; and

4. comply with all of the training requirements for providers of waiver services.

B. Providers must maintain adequate documentation to support service delivery and compliance with the approved POC and provide said documentation upon the department's request.

C. In order for a provider to bill for services, the waiver participant 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 participant is not present:

a. environmental accessibility adaptations;

b. personal emergency response systems; and

c. one-time transitional services.

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

D. If transportation is provided as part of a waiver service, the provider must comply with all of the state laws and regulations applicable to vehicles and drivers.

E. All services rendered shall be prior approved and in accordance with the POC.

F. Providers, including direct care staff, cannot live in the same residence as the participant, except host home contractors and companion care workers.

G. Providers of ADHC services must:

1. be licensed as ADHC providers by the state of Louisiana in accordance with R.S. 40:2120.41-2120.47;

2. comply with all of the department's rules and regulations; and

3. be enrolled as an ADHC provider with the Medicaid program.

a. ADHC facility staff shall meet the requirements of department rules and regulations, as well as state licensing provisions.

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).

§16703. Staffing Restrictions and Requirements

A. Payments shall not be made to persons who are legally responsible for the care of the waiver participant, which include:

1. parents of minor children;

2. spouses for each other;

3. legal guardians for adults or children with developmental disabilities; or

4. parents for their adult child with developmental disabilities, regardless of the legal status of the adult child.

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 participant.

1. Relatives must also comply with the following requirements:

a. become an employee of the participant's chosen waiver provider agency;

b. become a Medicaid enrolled provider agency; or

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

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

ii. have a Medicaid provider agreement executed by the fiscal agent as authorized by the Medicaid agency.

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).

Chapter 169. Reimbursement

§16901. Unit of Reimbursement

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

1. respite care;

2. housing stabilization transition;

3. housing stabilization;

4. community living supports (CLS);

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

b. there is a separate reimbursement rate for CLS when these services are shared;

5. professional services furnished by a/an:

a. psychologist;

b. speech therapist;

c. physical therapist;

d. occupational therapist;

e. social worker;

f. registered dietician;

6. supported employment;

a. individual placement;

b. micro-enterprise;

7. adult day health care;

8. pre-vocational service; and

9. day habilitation.

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

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

1. environmental accessibility adaptations; and

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

2. assistive technology/specialized medical equipment and supplies.

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

1. host home;

2. companion care services;

3. shared living services;

a. per diem rates are established based on the number of individuals sharing the living service module for both shared living non-conversion and shared living conversion services; and

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

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

F. Installation of a personal emergency response system (PERS) is reimbursed at a one-time fixed rate and maintenance of the PERS is reimbursed at a monthly rate.

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

H. Dental services are reimbursed at the Medicaid fee-for-service rate.

I. The assessment performed by the monitored in-home caregiving provider shall be reimbursed at the authorized rate or approved amount of the assessment when the service has been prior authorized by the plan of care.

J. Reimbursement Exclusion. No payment will be made for room and board under this waiver 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 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).