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

c. be Medicaid eligible, eligible for state developmental disability services and meet ICF/DD level of care.

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

C. Individuals who participate in the demonstration are not required to have a protected request date on the registry.

D. Children's choice waiver opportunities created using the MFP methodology do not create a permanent funding shift. These opportunities shall be funded on an individual basis for the purpose of this demonstration program only.

E. All other children's choice waiver provisions apply to the money follows the person rebalancing demonstration.

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

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

§11105. Money Follows the Person Rebalancing Demonstration

A. The Money Follows the Person (MFP) Rebalancing Demonstration is a federal demonstration program awarded by the Centers for Medicare and Medicaid Services to the department. The demonstration is a transition program that targets individuals using qualified institutional services and moves them to home and community-based long-term care services. The MFP rebalancing demonstration will stop allocation of opportunities when the demonstration expires.

1. For purposes of these provisions, a qualified institution is a hospital, nursing facility, or intermediate care facility for people with developmental disabilities.

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

1. Individuals with a developmental disability must:

a. be from birth through 20 years of age;

Chapter 113. Service

§11301. Service Cap

A. Effective May 20, 2007, children's choice services are capped at $17,000 per individual per plan of care year.

B. Participants are eligible to receive all medically necessary Medicaid State Plan services, including early periodic screening, diagnosis, and treatment (EPSDT) services.

C. Effective September 1, 2010, children's choice waiver services are capped at $16,660 per individual per plan of care year.

D. Effective August 1, 2012, children's choice services are capped at $16,410 per individual per plan of care year.

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

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

§11303. Service Definitions

A. The services in this §11303 are included in the service package for the Children's Choice Waiver. All services must be included on the approved plan of care which prior authorizes all services.

1. Children's choice services may be utilized to supplement EPSDT State Plan services that are prior approved as medically necessary.

2. Children's choice family supports services cannot be provided on the same day at the same time as EPSDT's personal care services.

3. Children's choice family supports services cannot be provided on the same day at the same time as any other children's choice waiver service except for the following:

a. environmental accessibility adaptations;

b. family training;

c. specialized medical equipment and supplies; or

d. support coordination.

4. Children's choice services cannot be provided in a school setting.

5. Services provided through a program funded under the Individuals with Disabilities Education Act (IDEA) must be utilized before accessing children's choice therapy services.

B. Support coordination consists of the coordination of services which will assist participants who receive children's choice services in gaining access to needed waiver and other Medicaid services, as well as needed medical, social, educational and other services, regardless of the funding source. The support coordinator is responsible for convening the person-centered planning team comprised of the participant, participant's family, direct service providers, medical and social work professionals, as necessary, and advocates who assist in determining the appropriate supports and strategies to meet the participant's needs and preferences. The support coordinator shall be responsible for the ongoing coordination of supports and services included in the participant's plan of care. Support coordinators shall initiate the process of assessment and reassessment of the participant's level of care and the review of plans of care as required.

1. Support coordination services are provided to all children's choice participants to assist them in gaining access to needed waiver services, Medicaid State Plan services, as well as needed medical, social, educational and other services regardless of the funding source for the services. Support coordinators provide information and assistance to waiver participants by directing and managing their services in compliance with the rules and regulations governing support coordination.

a. Support coordinators shall be responsible for ongoing monitoring of the provision of services included in the participant's approved plan of care.

b. Support coordinators shall also participate in the evaluation and re-evaluation of the participant's plan of care.

c. Support coordinators will have limited annual plan of care approval authority as authorized by OCDD as indicated in policy and procedures.

2. Support coordinators are responsible for providing assistance to participants who choose 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.

3. Provider Qualifications. Providers must have a current, valid support coordination license 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.

C. Center-based respite is service provided in a licensed respite care facility to participants unable to care for themselves. These services are furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

D. Environmental accessibility adaptations are physical adaptations to the home or vehicle provided when required by the participant's plan of care as necessary to ensure the health, welfare and safety of the participant, or which enable the participant to function with greater independence in the community, and without which the participant would require additional supports or institutionalization.

1. Such adaptations to the home may include:

a. the installation of ramps and/or grab-bars;

b. widening of doorways;

c. modification of bathroom facilities; or

d. installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the participant.

2. Adaptations which add to the total square footage of the home are excluded from this benefit.

3. Home modification funds are not intended to cover basic construction cost. For example, in a new home, a bathroom is already part of the building cost. Waiver funds can be used to cover the difference between constructing a bathroom and building an accessible or modified bathroom.

4. All services shall be in accordance with applicable state and local building codes.

5. An example of adaptation to the vehicle is a van lift.

6. Excluded is the purchase or lease of a vehicle and regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

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

8. Fire alarms, smoke detectors, and fire extinguishers are not considered environmental adaptations and are excluded.

9. Any services covered by Title XIX (Medicaid State Plan Services) are excluded.

E. Family training consists of formal instruction offered through training and education designed to assist the families of children's choice waiver participants in meeting the needs of their children.

1. The training and education must be conducted by professional organizations or practitioners who offer education or training appropriate to the needs of the child as identified in the plan of care.

2. Family training must be prior approved by the LGE and incorporated into the approved plan of care.

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

4. Payment for family training services includes coverage of registration and training fees associated with formal instruction in areas relevant to the participant's needs as identified in the plan of care. Payment is not available for the costs of travel, meals and overnight lodging to attend a training event or conference.

F. Family support services are services that enable a family to keep their child or family member at home, thereby enhancing family functioning. Services may be provided in the home or outside of the home in settings such as after school programs, summer camps, or other places as specified in the approved plan of care.

1. Family support includes:

a. assistance and prompting with eating, bathing, dressing, personal hygiene, and essential housekeeping incidental to the care of the child, rather than the child's family. The preparation of meals is included, but not the cost of the meals themselves; and

b. assistance with participating in the community, including activities to maintain and strengthen existing informal networks and natural supports. Providing transportation to these activities is also included.

2. Family members who provide family support services must meet the same standards of service, training requirements and documentation requirements as caregivers who are unrelated to the participant. Services cannot be provided by the following individuals:

a. legally responsible relatives (spouses, parents or step-parents, foster parents, or legal guardians); or

b. any other individuals who live in the same household with the waiver participant.

G. Specialized Medical Equipment and Supplies

1. Specialized medical equipment and supplies are devices, controls, or appliances, as specified in the plan of care, which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

2. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the participant.

3. All items shall meet applicable standards of manufacture, design and installation.

4. This service may also be used for routine maintenance or repair of specialized equipment. Some examples would include sip and puffer switches; other specialized switches; and voice-activated, light-activated, or motion-activated devices to access the participant's environment.

5. Routine maintenance or repair of specialized medical equipment is funded under this service.

6. Excluded are those durable and non-durable items that are available under the Medicaid State Plan. The Support Coordinator shall pursue and document all alternate funding sources that are available to the participant before submitting a request for approval to purchase or lease specialized medical equipment and supplies.

7. Excluded are those specialized equipment and supplies that are not of direct medical or remedial benefit to the participant such as, but not limited to:

a. appliances;

b. personal computers and software;

c. daily hygiene products;

d. rent subsidy;

e. food;

f. bed linens;

g. exercise equipment;

h. taxi fares, bus passes, etc;

i. pagers and telephones; and

j. home security systems.

H. Aquatic Therapy

1. Aquatic therapy uses the resistance of water to rehabilitate a participant with a chronic illness, poor or lack of muscle tone or a physical injury/disability.

2. Aquatic therapy is not for participants who have fever, infections and are bowel/ bladder incontinent.

I. Art Therapy

1. Art therapy is used to increase awareness of self and others; cope with symptoms, stress and traumatic experiences; enhance cognitive abilities; and as a mode of communication and enjoyment of the life-affirming pleasure of making art.

2. Art therapy is the therapeutic use of art by people who experience illness, trauma, emotional/behavioral or mental health problems; by those who have learning or physical disabilities, life-limiting conditions, brain injuries or neurological conditions and/or challenges in living; and by people who strive to improve personal development.

J. Music Therapy

1. Music therapy services help participants improve their cognitive functioning, motor skills, emotional and affective development, behavior and social skills and quality of life.

K. Sensory Integration

1. Sensory integration is used to improve the way the brain processes and adapts to sensory information, as opposed to teaching specific skills. Sensory integration involves activities that provide vestibular, proprioceptive and tactile stimuli which are selected to match specific sensory processing deficits of the child.

L. Hippotherapy/Therapeutic Horseback Riding

1. Hippotherapy/therapeutic horseback riding are services used to promote the use of the movement of the horse as a treatment strategy in physical, occupational and speech-language therapy sessions for people living with disabilities.

2. Hippotherapy improves muscle tone, balance, posture, coordination, motor development as well as motor planning that can be used to improve sensory integration skills and attention skills.

a. Specially trained therapy professionals evaluate each potential participant on an individual basis to determine the appropriateness of including hippotherapy as a treatment strategy.

b. Hippotherapy requires therapy sessions that are one-on-one with a licensed physical therapist, speech therapist or occupational therapist who works closely with the horse professional in developing treatment strategies. The licensed therapist must be present during the hippotherapy sessions.

c. Hippotherapy must be ordered by a physician with implementation of service, treatment strategies and goals developed by a licensed therapist. Services must be included in the participant’s plan of care.

3. Therapeutic horseback riding teaches riding skills and improves neurological function and sensory processing.

a. Therapeutic horseback riding must be ordered by a physician with implementation of service, treatment strategies and goals developed by a licensed therapist. Services must be included in the participant’s plan of care.

M. Housing Stabilization Transition Services

1. 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. The service is provided while the participant is in an institution and preparing to exit the institution using the waiver.

2. Housing stabilization transition services include the following components:

a. 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:

i. access to housing;

ii. meeting the terms of a lease;

iii. eviction prevention;

iv. budgeting for housing/living expenses;

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

vi. home management;

vii. establishing credit; and

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

b. assisting the participant to view and secure housing as needed, which may include arranging for and providing transportation;

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

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

i. includes short and long term measurable goals for each issue;

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

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

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

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

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

4. Participants may not exceed 165 combined units of this service and housing stabilization services.

a. Exceptions to exceed the 165 unit limit may be made only with written approval from the Office for Citizens with Developmental Disabilities.

N. Housing Stabilization Services

1. 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.

2. Housing stabilization services include the following components:

a. 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:

i. access to housing;

ii. meeting the terms of a lease;

iii. eviction prevention;

iv. budgeting for housing/living expenses;

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

vi. home management;

vii. establishing credit; and

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

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

d. 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.);

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

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

g. providing supports to retain housing or locate and secure housing to continue community-based supports if the

participant's housing is placed at risk (e.g., eviction, loss of roommate or income); this includes locating new housing, sources of income, etc.

3. Housing stabilization services are only available upon referral from the support coordinator. This service is not duplicative of other waiver services, including support coordination. This service is only available to persons who are residing in a state of Louisiana permanent supportive housing unit.

4. Participants may not exceed 165 combined units of this service and housing stabilization transition services.

a. Exceptions to exceed the 165 unit limit may be made only with written approval from the Office for Citizens with Developmental Disabilities.

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

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Chapter 115. Provider Participation Requirements

Subchapter A. Provider Qualifications

§11501. Support Coordination Providers and Service Providers

A. Support Coordination Providers. Families of waiver participants shall choose one support coordination agency from those available in their region to provide developmental disabilities support coordination services.

B. Service Providers. Agencies licensed to provide personal care attendant services may enroll as a provider of children's choice services with the exception of support coordination services and therapy services. Agencies that enroll to be a children's choice service provider shall provide family support services, and shall either provide or subcontract for center-based respite, environmental accessibility adaptations, family training, and specialized medical equipment and supplies. Families of participants shall choose one service provider agency from those available in their region that will provide all waiver services, except support coordination.

1. Family members who provide family support services must meet the same standards of service, training requirements and documentation requirements, as caregivers who are unrelated to the participant. Service cannot be provided by the following:

a. legally responsible relatives (spouses, parents or step-parents, foster parents, or legal guardians); or

b. any other individuals who live in the same household with the waiver participant.

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

§11529. Professional Services Providers

A. Professional services are direct services to participants, based on need, that may be utilized to increase the participant's independence, participation and productivity in the home and community. Service intensity, frequency and duration will be determined by individual need. Professional services include the following:

1. aquatic therapy;
2. art therapy;
3. music therapy;
4. sensory integration; and
5. hippotherapy/therapeutic horseback riding.

B. Professional services must be delivered with the participant present and in accordance with the plan of care.

C. Children's choice services cannot be provided on the same day at the same time as any other waiver or State Plan service except for the following services:

1. environmental accessibility adaptations;

2. family training;

3. specialized medical equipment and supplies;

4. support coordination; and

5. therapy

D. Children's choice services cannot be provided in a school setting.

E. Provider Qualifications

1. Individual practitioners must enroll as a Medicaid provider;

2. Have a current, valid license or certification from the appropriate governing board for that profession; and

3. Possess one year of post licensure or certification experience.

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

F. All services rendered shall be prior approved and in accordance with the plan of care.

G. All services must be documented in service notes which describe the services rendered and progress towards the participant's personal outcomes and his/her plan of care.

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

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

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

Chapter 121. Reimbursement Methodology

§12101. Unit of Reimbursement

A. Case management services shall be reimbursed at a flat monthly rate billed for each waiver participant served in accordance with the conditions and procedures contained in the Case Management Services provider manual.

B. Direct service providers shall be reimbursed according to the following unit of reimbursement approach. Actual rates will be published in the Children's Choice Waiver provider manual, and will be subsequently amended by direct notification to the affected providers. For services provided by a subcontractor agency, the enrolled direct service provider shall coordinate and reimburse the subcontractor according to the terms of the contract and retain the administrative costs.

1. Family support, crisis support, center-based respite, aquatic therapy, art therapy, music therapy, sensory integration and hippotherapy/therapeutic horseback riding services shall be reimbursed at a flat rate per 15-minute unit of service and reimbursement shall not be made for less than 15-minute (one quarter-hour) of service. This covers both service provision and administrative costs.

a. Up to two participants may choose to share family support services if they share a common provider of this service.

b. Up to two participants may choose to share crisis support services if they share a common provider of this service.

c. There is a separate reimbursement rate when these services are shared.

2. Family training shall be reimbursed at cost.

3. Environmental accessibility adaptations and specialized medical equipment and supplies shall be reimbursed at cost plus a set administrative add-on per project.

4. Direct Support Professionals Wages

a. The minimum hourly rate paid to providers for full-time equivalent (FTE) direct support professionals shall be the federal minimum wage in effect at the time.

5. Direct Support Worker Wages

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

i. Effective October 1, 2021, providers of Medicaid home and community-based waiver services operated through the Office for Citizens with Developmental Disabilities employing defined direct support workers will receive the equivalent of a $2.50 per hour rate increase.

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

iii. The minimum hourly wage floor paid to direct support workers shall be $9.00 per hour.

iv. All providers of services affected by this rate increase shall be subject to a direct support worker wage floor of $9.00 per hour. This wage floor is effective for all affected direct support workers of any work status (full-time, part-time, etc.)

v. The Department of Health reserves the right to adjust the direct support worker wage floor as needed through appropriate rulemaking promulgation consistent with the Louisiana Administrative Procedure Act.

b. Establishment of Audit Procedures for Direct Support Worker Wage Floor

i. The wage enhancement payments reimbursed to providers shall be subject to audit by the department.

ii. Providers shall provide to the department or its representative all requested documentation to verify compliance with the direct support worker wage floor.

iii. This documentation may include, but not be limited to, payroll records, wage and salary sheets, check stubs, etc.

iv. Providers shall produce the requested documentation upon request and within the time frame provided by the department.

v. Noncompliance or failure to demonstrate that the wage enhancement was paid directly to direct support workers may result in:

(a). sanctions; or

(b). disenrollment in the Medicaid Program.

c. Sanctions

i. The provider will be subject to sanctions or penalties for failure to comply with this Rule or with requests issued by LDH pursuant to this Rule. The severity of such action will depend on:

(a). failure to pay I/DD HCBS direct support workers the floor minimum of $9.00 per hour;

(b). the number of employees identified as having been paid less than the $9.00 per hour floor;

(c). the persistent failure to pay the floor minimum of $9.00 per hour; or

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

d. New Opportunities Waiver Fund

i. The department shall deposit civil fines and the interest collected from providers into the New Opportunities Waiver Fund.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1987 (September 2002), LR 33:1872 (September 2007), amended by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 34:250 (February 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 36:324 (February 2010), LR 36:2280 (October 2010), LR 37:2157 (July 2011), LR 39:2504 (September 2013), LR 40:68 (January 2014), LR 41:128 (January 2015), LR 42:896 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:40 (January 2022).

Chapter 123. Self-Direction Initiative

§12301. Self-Direction Service Delivery Option

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

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

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

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

a. adhering to the health and welfare safeguards identified by the team, including the application of a comprehensive monitoring strategy and risk assessment and management systems;

3. participation in the development and management of the approved budget:

a. this annual budget is determined by the recommended service hours listed in the participant's plan of care to meet his/her needs; and

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

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

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

C. Termination of the Self-Direction Service Option. Termination of participation in the self-direction service delivery option requires a revision of the plan of care, 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 delivery option and return to the traditional provider agency management of services.

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

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

b. the participant is no longer able to direct his/her own care and there is no authorized 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 a one year period, 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 approved budget;

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.

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

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