NOTICE OF INTENT

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

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

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities propose to amend LAC 50:XXI.Chapters 137–143 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Act 450 of the 2021 Regular Session of the Louisiana Legislature directed the Department of Health to provide dental care to each person age 21 or older enrolled in any Medicaid waiver program for persons with developmental or intellectual disabilities. In compliance with Act 450, the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities propose to amend the provisions governing the New Opportunities Waiver in order to add adult dental services as a covered service. The department also proposes to amend the provisions governing the delivery of services in the New Opportunities Waiver under certain

conditions including allowing family members as paid caregivers, the 16-hour rule and shared services.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XXI. Home and Community-Based Services Waivers
Subpart 11. New Opportunities Waiver

Chapter 137. General Provisions

§13701. Introduction

A. The New Opportunities Waiver (NOW), hereafter referred to as the NOW, is designed to enhance the home and community-based services and supports available to individuals with developmental disabilities, who would otherwise require an intermediate care facility for persons with developmental disabilities (ICF-IDD) level of care. The mission of the NOW is to utilize the principle of self-determination and supplement the family and/or community supports while supporting the dignity, quality of life and security in the everyday life of an individual, and maintaining that individual in the community. Services provided in the NOW are community-based, and are designed to allow an individual experience that mirrors the experiences of individuals without disabilities. These services are not to be restrictive, but liberating, by empowering individuals to experience life in the most fulfilling manner as defined by the individual while still assuring health and safety. In keeping with the principles of self-determination,

NOW includes a self-direction service delivery option. This allows for greater flexibility in hiring, training, and general service delivery issues.

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

C. ...

D. In order for the NOW provider to bill for services, the ~~participant~~beneficiary and the direct service provider, professional or other practitioner rendering service, must be present at the time the service is rendered unless otherwise allowed in rule. The service must be documented in service notes describing the service rendered and progress towards the ~~participant's~~beneficiary's personal outcomes and CPOC.

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

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

G. ~~Providers shall follow the regulations and requirements as specified in the NOW provider manual~~Repealed.

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

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

§13702. Settings for Home and Community-Based Services

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

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

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

§13703. ~~Participant~~Beneficiary Qualifications and Admissions Criteria

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

1. – 3. ...

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

5. – 8. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1201 (June 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental

Disabilities, LR 40:96 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2528 (December 2017), LR 45:43 (January 2019), LR 48:

§13704. Needs-Based Assessment

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

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

B. – C.4.e. ....

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

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

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

§13705. Denial of Admission or Discharge Criteria

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

1. ...

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

4. ...

5. the ~~participant~~beneficiary is admitted to an ICF-IDD facility or nursing facility with the intent to stay and not to return to waiver services. The waiver ~~participant~~beneficiary may return to waiver services when documentation is received from the treating physician that the admission is temporary and shall not exceed 90 days. The ~~participant~~beneficiary will be discharged from the waiver on the ninety-first day if the ~~participant~~beneficiary is still in the ICF-IDD or nursing facility;

6. the health and welfare of the ~~participant~~beneficiary cannot be assured through the provision

of NOW services within the ~~participant's~~beneficiary's approved comprehensive plan of care;

7. ...

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

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

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

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

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

§13706. Resource Allocation

A. ...

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

2. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Service Financing and the Office for Citizens with Developmental Disabilities, LR 43:2528 (December 2017), LR 48:

§13707. Programmatic Allocation of Waiver Opportunities

A. The intellectual/developmental disabilities request for services registry, hereafter referred to as "the registry," ~~shall be used to identify persons with intellectual and/or~~ is the list that documents and maintains the person's name and protected request date for waiver services. A person's protected request date for any OCDD waiver is the date of the first face-to-face interview in which he/she applied for waiver services and is determined eligible for developmental disabilities ~~who are waiting for~~ services by the entry unit. The order of entry into an OCDD waiver ~~opportunity~~is needs based from the registry arranged by an urgency of need assessment and date of application for developmentally disabled (DD) waiver services.

B. ~~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 the urgency of need and date of application for developmentally disabled (DD)~~Funded OCDD waiver ~~services.~~opportunities shall be offered based on the following priority groups:

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

up the private ICF-IDD bed to an individual living at a publicly operated ICF-IDD when it transitioned to a private ICF-IDD through a cooperative endeavor agreement (CEA Facility). Individuals requesting to transition from a publicly operated ICF-IDD are awarded a slot when one is requested, and their health and safety can be assured in an OCDD waiver. This also applies to individuals who were residing in a publicly operated facility at the time the facility was privatized and became a CEA facility. The funded waiver opportunity will be reserved for a period not to exceed 120 days; however, this 120-day period may be extended as needed.

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

C. ~~Funded OCDD waiver opportunities will be offered based on the following priority groups:~~The Office for Citizens with Developmental Disabilities has the responsibility to monitor the utilization of NOW opportunities. At the discretion of the OCDD, specifically allocated waiver opportunities may be reallocated, to better meet the needs of citizens with developmental disabilities in the state of Louisiana.

~~1. 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:~~

~~a. the bed being vacated by the alternate in the private ICF-ID must be reserved for 14 days for the placement of a person being discharged from a publicly-operated facility. The person's discharge from a publicly-operated facility and his/her subsequent placement in a private ICF-ID is to occur as close as possible to the actual discharge of the alternate from the private ICF-ID and is not to exceed 14 days from the date of the alternate's discharge and certification for the waiver. The bed may be held vacant beyond the 14 days with the concurrence of the private ICF-ID provider;~~

~~b. the funded waiver opportunity will be reserved for a period not to exceed 120 days; however, this 120-day period may be extended as needed;~~

~~2. individuals on the registry who have 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~~1. – 2. Repealed.

D. ~~The Office for Citizens with Developmental Disabilities has the responsibility to monitor the utilization of NOW waiver opportunities. At the discretion of the OCDD, specifically allocated~~ Funded waiver opportunities ~~may~~ will only be ~~reallocated~~allocated to ~~better meet the needs of citizens with developmental disabilities in the State of Louisiana~~individuals who successfully complete the financial and medical eligibility process required for waiver certification.

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 31:2900 (November 2005), amended

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

Chapter 139. Covered Services

§13901. Individual and Family Support Services

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

1. Individual and family support day (IFS-D) services will be authorized during waking hours for up to 16 hours when natural supports are unavailable in order to provide continuity of services to the ~~participant~~beneficiary. Waking

hours are the period of time when the ~~participant~~beneficiary is awake and not limited to traditional daytime hours as outlined in the CPOC.

a. ...

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

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

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

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

d. A review shall include review of log notes indicating instances when IFS-N staff was awakened to attend to the ~~participant~~beneficiary. Also included in the review is

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

e. ...

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

C. IFS (day or night) services include:

C.1. – C.5. ...

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

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

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

1. ~~Reimbursement shall not be paid for~~IFS-D services ~~furnished by a legally responsible relative. A legally responsible relative~~ and IFS-N services will not be authorized or provided to the beneficiary while the beneficiary is ~~defined as the parent of a minor child, foster parent, curator, tutor, legal guardian, or the participant's spouse~~in a center-based respite facility.

2. IFS-D and IFS-N services ~~shall~~will not ~~include services~~be authorized or provided ~~in~~to the ~~IFS-D or IFS-N worker's residence, regardless of the relationship~~beneficiary while the beneficiary is receiving monitored in-home caregiving services.

3. ~~IFS-D and IFS-N services will~~Beneficiaries receiving adult companion care services are not eligible ~~be authorized or provided~~ to ~~the participant while the participant is in a center-based respite facility~~receive individual family support services.

E. Staffing Criteria and Limitations

1. ~~IFS-D or~~ Family members who provide IFS~~-N~~ services ~~may be provided by a member of~~must meet the

~~participant's family, provided that the participant does not live in the family member's residence and the family member is not the legally responsible relative as defined in §13901.D.1~~same standards as providers or direct care staff who are unrelated to the beneficiary. Service hours shall be capped at 40 hours per week, Sunday to Saturday, for services delivered by family members living in the home.

2. ~~Family members who provide IFS~~Legally responsible individuals (such as a parent or spouse) and legal guardians may provide individual and family support services ~~must meet the~~for a beneficiary provided that the care is extraordinary in comparison to that of a beneficiary of the same ~~standards as providers or direct~~ age without a disability and the care ~~staff who are unrelated to the participant~~is in the best interest of the beneficiary.

3. ~~An IFS-D or IFS-N worker/shared supports worker shall not work more than 16 hours in a 24-hour period unless there is a documented emergency or a time-limited non-routine need that is documented in the approved CPOC or granted in writing by the OCDD Waiver director/designee~~Repealed.

F. – G ...

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

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

§13902 Individual and Family Support Supplemental Payments

A. – B.2.b.ii. ...

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for

Citizens with Developmental Disabilities, LR 46:1681 (December 2020), LR 48:

§13903. Center-Based Respite Care

A. Center-based respite (CBR) care is temporary, short-term care provided to a ~~participant~~beneficiary with developmental disabilities who requires support and/or supervision in his/her day-to-day life due to the absence or relief of the primary caregiver. While receiving center-based respite care, the ~~participant's~~beneficiary's routine is maintained in order to attend school, work or other community activities/outings. The respite center is responsible for providing transportation for community outings, as that is included as part of its reimbursement. ~~Individual and family support services (both day and night) will not be reimbursed while the participant is in a center-based respite facility.~~

B. Exclusions~~. The cost of room and board is not included in the reimbursement paid to the respite center.~~

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

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

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

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

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

D. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1203 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1648 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:72 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:51 (January 2018), LR 48:

§13905. Community ~~Integration~~Life Engagement Development

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

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

C. Service Limitations. Services shall not exceed 60 hours per ~~participant~~beneficiary per CPOC year which includes the combination of shared and non-shared community integration development.

D. ...

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

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

§13907. Supported Independent Living

A. Supported independent living (SIL) assists the ~~participant~~beneficiary to acquire, improve or maintain those social and adaptive skills necessary to enable a ~~participant~~beneficiary to reside in the community and to participate as independently as possible. SIL services include assistance and/or training in the performance of tasks such as personal grooming, housekeeping and money management. Payment for this service includes oversight and administration and the development of service plans for the enhancement of socialization with age-appropriate activities that provide

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

B. Place of Service. Services are provided in the ~~participant's~~beneficiary's residence and/or in the community. The ~~participant's~~beneficiary's residence includes his/her apartment or house, provided that he/she does not live in the residence of any legally responsible relative. An exception will be considered when the ~~participant~~beneficiary lives in the residence of a spouse or disabled parent, or a parent ~~age~~aged 70 years or older. Family members who are not legally responsible relatives ~~as defined in §13901.D.1,~~ can be SIL workers provided they meet the same qualifications as any other SIL worker. A legally responsible relative is defined as a parent of a minor child, foster parent, curator, tutor, legal guardian, or the beneficiary's spouse.

C. Exclusions

1. ...

2. SIL shall not include the cost of:

a. – b. ...

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

2.d. – 3. ...

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

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

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

E. ...

F. Provider Responsibilities

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

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

2. – 3. ...

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

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

§13909. Substitute Family Care

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

B. ...

C. Exclusions~~. The following exclusions apply to SFC services.~~

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

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

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

D. ...

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

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

§13911. Day Habilitation

A. Day habilitation is provided in a community-based setting and provides the ~~participant~~beneficiary assistance with social and adaptive skills necessary to enable the ~~participant~~

beneficiary to participate as independently as possible in the community. These services focus on socialization with meaningful age-appropriate activities which provide enrichment and promote wellness, as indicated in the ~~participant's~~beneficiary's CPOC. Day habilitation services are provided in a variety of community settings, (i.e. local recreation department, garden clubs, libraries, etc.) other than the person's residence, except for virtual habilitation services, and are not limited to a fixed-site facility.

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

2. Day habilitation services shall be coordinated with any therapy, prevocational service, or supported employment models that the ~~participant~~beneficiary may be receiving. The ~~participant~~beneficiary does not receive payment for the activities in which he/she are engaged. The

~~participant~~beneficiary must be 18 years of age or older in order to receive day habilitation services.

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

B. ~~Service Limits. Services can~~Day Habilitation may be ~~provided one or more hours per day but not to exceed eight hours per day or 8,320 one quarter hour units of~~delivered in a combination of these three service ~~per CPOC year.~~types:

1. onsite day habilitation

2. community life engagement

3. virtual day habilitation

C. ~~Licensing Requirements. Providers must be licensed by the Department of Health and as a home and community-based services provider and must meet the module specific requirements for the service being~~ Day Habilitation is provided on a regularly scheduled basis and may be scheduled on a plan of care for one or more days per week and may be prior authorized for up to 8,320 units of service in a plan of care year. A standard unit of service is a 15-minute increment.

D. Licensing Requirements. Providers must be licensed by the Department of Health and as a home and community-based

services provider and must meet the module specific requirements for the service being provided.

E. Service Limitations

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1204 (June 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:73 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:53 (January 2018), LR 48:

§13913. Supported Employment

A. Supported employment is competitive work in an integrated work setting, or employment in an integrated work

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

B. ...

C. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment cannot be provided at worksites that are facility based, or other similar types of vocational services furnished in specialized facilities that are not part of the general workplace. Supported employment includes activities needed by waiver ~~participants~~beneficiaries to sustain paid work, including supervision and training and is based on an individualized service plan. Supported employment may include assistance and prompting with:

1. – 8. ...

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

1. ~~A one-to-one model of~~Individual supported employment ~~is a placement strategy in which an employment specialist (job coach) places a person into competitive~~ one-to-one services include all aspects of the supported employment, ~~provides training and support and then gradually reduces time and assistance at the work site through formation of natural supports. This service is time limited to six to eight weeks in duration~~process including assessments, development, placement, job retention, and stabilization that are necessary to get an individual to work in an individual competitive job in the community.

2. ~~Follow along~~ Follow-along support services ~~are designed for participants who are in supported employment and have been placed in a work site and only require minimum oversight for follow along at the job site. This service is limited to 24 days per CPOC year~~provide ongoing supports to individuals and their employers who need the support to maintain their job in integrated work settings in the general workforce. The amount of support is determined for each individual based on

the individual's ability to be independent in the job. Follow-along services may be delivered virtually.

3. ~~Mobile work crew/enclave~~Group employment is an employment setting in which a group of two ~~or more participants, but no more than~~ to eight ~~perform~~beneficiaries work to complete jobs in a variety of locations ~~under the supervision of a permanent employment specialist (job coach/supervisor). This service is up to eight hours a day, five days per week~~in the community under the supervision of an employment specialist in a manner that promotes integration into the workplace and interaction between beneficiaries and people without disabilities in those workplaces that are in the community.

E. Service Exclusions

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

2. When supported employment services are provided at a work site in which persons without disabilities are ~~employees~~employed, payment will be made only for the adaptations, supervision and training required by ~~participants~~beneficiaries receiving waiver services as a result

of his/her disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

3. ~~Services~~Supported employment services are not available to ~~participants~~beneficiaries who are eligible ~~and have been accepted~~ to participate in programs funded under section 110 of the Rehabilitation Act of 1973 or ~~section~~sections 602(16) and (17) of the Individuals with Disabilities Education Act~~,~~ [20 U.S.C. 1401(~~16~~26) and (~~71~~29), as amended, and those covered under the Medicaid State Plan, if applicable.

F. Service Limits

1. ~~One~~Individual supported employment one-to-one ~~intensive~~ services shall not exceed ~~1,280~~2,880 ~~one quarter~~ one-quarter hour units (15 minute increments)per CPOC year. ~~Services shall be limited to eight hours a day, five days a week, for six to eight weeks.~~

2. ~~Follow along~~Both individual and virtual supported employment follow-along services shall not exceed ~~24 days~~960 one-quarter hour units (15 minute increments) per CPOC year.

3. ~~Mobile crew/enclave~~Group supported employment services shall not exceed 8,320 ~~one quarter~~one-quarter hour units of service per CPOC year, without additional documentation and approval. ~~This is eight hours per day, five days per week~~.

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

G. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1205 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:74 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:53 (January 2018), LR 48:

§13915. Transportation for Day Habilitation and Supported Employment Models

A. Transportation provided for the ~~participant~~beneficiary to the site of the day habilitation or supported employment model, or between the day habilitation and supported employment model site (if the ~~participant~~beneficiary receives services in more than one place) is reimbursable when day habilitation or supported employment model has been provided. Reimbursement may

be made for a one-way trip. There is a maximum fee per day that can be charged for transportation regardless of the number of trips per day.

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

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

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

B. Licensing Requirements. Providers must be licensed by the Department of Health as a home and community- based services provider and meet the module specific requirements for the service being provided. The ~~licensed~~ provider must ~~carry $1,000,000 liability~~ have insurance coverage on ~~the~~any vehicles used in transporting ~~the participants~~a beneficiary that meets current home and community-based services providers licensing standards.

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

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

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

§13917. Prevocational Services

A. Prevocational services are ~~intended to prepare a participant for paid employment or volunteer opportunities in the community to the participant's highest level. Prevocational~~ individualized, person centered services ~~allow~~ that assist the ~~individual to develop general, non-job-task-specific strengths and skills that contribute to employability~~beneficiary in ~~paid employment in integrated~~ establishing their path to obtain individualized community ~~settings~~employment. This service is time limited and targeted for people who have an interest in becoming employed in an individual job in the community but may need additional skills, information and experiences to determine their employment goal and to become successfully employed. Beneficiaries receiving prevocational services may choose to

leave this service at any time or pursue employment opportunities at any time.

~~1. Prevocational services are intended to develop and teach general skills such as:~~

~~a. the ability to communicate effectively with supervisors, co-workers, and customers;~~

~~b. accepted community workplace conduct and dress;~~

~~c. the ability to follow directions and attend to tasks;~~

~~d. workplace problem solving skills and general workplace safety; and~~

~~e. mobility training.~~

~~2. Prevocational services are provided in a variety of locations in the community and are not limited to a fixed-site facility. Participants receiving prevocational services must have an employment related goal as part of their CPOC and service plan. The general habilitation activities must support their employment goals. Prevocational services are designed to create a path to integrated community based employment for which an individual is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Assistance with personal care may be a~~

~~component of prevocational services, but may not comprise the entirety of the service~~1. – 2. Repealed.

B. Prevocational services ~~are provided on a regularly scheduled basis and~~ may be ~~scheduled on a comprehensive plan of care for one or more days per week and may be prior authorized for up to 8,320 units of service~~delivered in a ~~plan year with appropriate documentation. A standard unit is one quarter hour.~~ combination of these three service types:

1. onsite prevocational services

2. community career planning

3. virtual prevocational services

C. ~~Exclusions. The following service exclusions apply to prevocational~~Prevocational services are to be provided in a variety of locations in the community and are not to be limited to a fixed site facility. Activities associated with prevocational services should focus on preparing the beneficiary for integrated individual employment in the community. These services are operated through a provider agency that is licensed by the appropriate state licensing agency. Beneficiaries receiving prevocational services must participate in activities designed to establish an employment related goal as part their CPOC. Prevocational services are designed to help create a path to integrated community-based employment for which a beneficiary is compensated at or above minimum wage, but not less than the

customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

1. ~~Services are not available to participants who are eligible to participate in programs funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act, 20 U.S.C. 1401(16) and (71)~~Repealed.

D. ~~Service Limits. Services shall not exceed eight hours a day, five days a week, and cannot exceed 8,320 one quarter hour units of service per CPOC year. Additionally, prevocational~~ Prevocational services are ~~time limited to four years, after which the participant should be able to transition into employment. Exceptions to the four-year limitation~~ provided on a regularly scheduled basis and may be ~~approved at the discretion~~ scheduled on a comprehensive plan of ~~OCDD program office~~care for one or more days per week and may be prior authorized for up to 8,320 units of service in a plan year with appropriate documentation. A standard unit is one-quarter hour (15 minute increment).

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

Exclusions. The following service ~~being provided~~exclusions apply to prevocational services.

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

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

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

4. Transportation is billed as a separate service.

F. Service Limits

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

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1205 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:75 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:55 (January 2018), LR 48:

§13919. Environmental Accessibility Adaptations

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

services, the ~~participant~~beneficiary would require additional supports or institutionalization.

B. Such adaptations may include:

1. – 3. ...

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

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

C. ...

1. Any service covered under the Medicaid state plan shall not be authorized by NOW. The environmental accessibility adaptation(s) must be delivered, installed, operational and accepted by the ~~participant~~beneficiary/authorized representative in the CPOC year for which it was approved. The environmental accessibility adaptation(s) must be billed and reimbursed according to the Medicaid billing guidelines established by LDH policy. A written itemized detailed bid, including drawings with the dimensions of the existing and proposed floor plans relating to the modification, must be obtained and submitted for prior authorization. Modifications may be applied to rental or leased property with the written approval of the landlord and approval

of the human services authority or district. Reimbursement shall not be paid until receipt of written documentation that the job has been completed to the satisfaction of the ~~participant~~beneficiary.

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

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

a. air conditioning or heating;

b. flooring;

c. roofing, installation or repairs;

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

e. furniture or appliances~~.~~; or

f. whole home generators.

4. ...

5. Home modification ~~is~~funds are not intended to cover basic construction cost. For example, funds may be used to cover the difference between constructing a bathroom and building an accessible or modified bathroom, but in any

situation funds must be used to pay for a specific approved adaptation.

6. ...

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

E. – E.2. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1206 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:75 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:55 (January 2018), LR 48:

§13921. Specialized Medical Equipment and Supplies

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

1. – 3. ...

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

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

D. Exclusion. Excluded are specialized equipment and supplies that are of general utility or maintenance, but are not of direct medical or remedial benefit to the ~~participant~~beneficiary. ~~Refer to the New Opportunities Waiver provider manual for a list of examples.~~Excluded also are those durable and non-durable items that are available under the Medicaid State Plan.

E. Service Limitations. There is a cap of $1,000 per three year period for a ~~participant~~beneficiary for specialized equipment and supplies. On a case-by-case basis, with supporting

documentation and based on need, a ~~participant~~beneficiary may be able to exceed this cap with the prior approval of OCDD central office.

F. ...

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

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

§13923. Personal Emergency Response Systems

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

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

1. – 3. ...

C. Coverage of the PERS is limited to the rental of the electronic device. PERS services shall include the cost of maintenance and training the ~~participant~~beneficiary to use the equipment.

D. ...

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

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

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

for Citizens with Developmental Disabilities, LR 40:76 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:

§13925. Professional Services

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

1. – 2. ...

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

4. ...

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

B. Professional services are limited to the following services.

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

2. – 3. ...

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

or more professional services may be utilized in the same day, but not at the same time.

D. – E.5. ...

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

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

§13927. Skilled Nursing Services

A. Skilled nursing services are medically necessary nursing services ordered by a physician and provided by a licensed registered nurse, nurse practitioner, or a licensed practical nurse working under the supervision of a registered nurse. Skilled nursing services shall be provided by a licensed, enrolled home health agency and require an individual nursing service plan. These services must be included in the

~~participant's~~beneficiary's approved CPOC. All available Medicaid State Plan skilled nursing services must be ~~utilized~~exhausted before accessing this service. ~~Participants~~Beneficiaries, up to the age of 21, must access these services as outlined on the CPOC through the Home Health Program in the Medicaid State Plan pursuant to the EPSDT benefit.

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

C. ...

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1208 (June 2004), amended by the

Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1651 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:77 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:56 (January 2018), LR 46:1681 (December 2020), LR 48:

§13929. One-Time Transitional Expenses

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

B. Allowable transitional expenses include:

1. the purchase of essential furnishings, such as:

a. bedroom and living room furniture~~;~~,

b. dining table and chairs~~;~~,

c. window blinds~~;~~,

d. eating utensils~~;~~, and

e. ...

2. – 3. ...

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

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

D. – E. ...

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

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

§13931. Adult Companion Care

A. Adult companion care services assist the ~~participant~~beneficiary to achieve and/or maintain the outcomes

of increased independence, productivity and inclusion in the community. These services are designed for an individual who lives independently and can manage his/her own household with limited supports. The companion is a principal care provider chosen by the ~~participant~~beneficiary, who provides services in the ~~participant's~~beneficiary's home. The companion must be at least 18 years of age and lives with the ~~participant~~beneficiary as a roommate. Adult companion care services are furnished through a licensed provider organization as outlined in the ~~participant's~~beneficiary's CPOC. This service includes:

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

2. – 3. ...

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

1. ...

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

C. Provider Responsibilities

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

a. – c. ...

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

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

a. ...

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

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

d. ...

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

a. ...

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

D. Companion Responsibilities

1. – 1.c. ...

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

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

E. Service Limits

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

F. Service Exclusions

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

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

a. – b. ...

c. substitute family care; ~~or~~

d. skilled nursing~~.~~; or

e. monitored in-home caregiving (MIHC)

G. ...

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

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

§13935. Housing Stabilization Transition Service

A. Housing stabilization transition service enables ~~participants~~beneficiaries who are transitioning into a permanent supportive housing unit, including those transitioning from

institutions, to secure their own housing. The service is provided while the ~~participant~~beneficiary is in an institution and preparing to exit the institution using the waiver. The setting for the permanent supportive housing must be integrated in the greater community, and support full access to the greater community by the ~~participant~~beneficiary. The service includes the following components:

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

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

b. – h. ...

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

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

a. ...

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

A.3.c. – B. ...

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

1. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:78 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:57 (January 2018), LR 48:

§13937. Housing Stabilization Service

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

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

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

a. – h. ...

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

3. developing an individualized housing stabilization service provider plan based upon the housing assessment that includes short and long-term measurable goals for each issue, establishes the ~~participant's~~beneficiary's approach to meeting the goal, and identifies where other provider(s) or services may be required to meet the goal. This includes updating the housing support plan annually or as needed due to changes in the beneficiary's situation or status;

4. ~~providing supports and interventions according to the individualized housing support plan. If additional supports or services are identified as needed outside the scope of~~ participating in the development of the CPOC, incorporating elements of the housing stabilization service~~, the needs must be communicated to the support coordinator~~ provider plan. This

includes participation in plan of care renewals and updates as needed;

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

6. ~~updating the housing support plan annually or as needed due to changes in~~ providing ongoing communication with the landlord or property manager regarding the ~~participant's situation or status~~beneficiary's disability, accommodations needed, and components of emergency procedures involving the landlord or property manager; and

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

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

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

1. ...

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

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

§13939. Monitored In-Home Caregiving Services

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

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

2. This goal is achieved by promoting a cooperative relationship between a beneficiary, a principal caregiver, the professional staff of a monitored in-home caregiver agency provider, and the beneficiary's support coordinator.

B. The principal caregiver is responsible for supporting the beneficiary to maximize the highest level of independence possible by providing necessary care and supports that may include:

1. supervision or assistance in performing activities of daily living;

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

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

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

5. supervision or assistance while escorting/accompanying the individual outside of the home to perform tasks, including instrumental activities of daily

living, health maintenance, or other needs as identified in the plan of care, and to provide the same supervision or assistance as would be rendered in the home; and

6. extension of therapy services to maximize independence when the caregiver has been instructed in the performance of the activities by a licensed therapist or registered nurse.

C. Service Exclusions and Restrictions

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

a. individual family support;

b. center-based respite;

c. supported independent living;

d. adult companion care; or

e. skilled nursing care;

D. Monitored in-home caregiving providers must be agency providers who employ professional nursing staff, including a registered nurse and a care manager, and other professionals to train and support principal caregivers to perform the direct care activities performed in the home.

1. The agency provider must assess and approve the home in which services will be provided, and enter into

contractual agreements with caregivers whom that agency has approved and trained.

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

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

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

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

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

G. Provider Qualifications

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

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

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

4. The principal caregiver must:

a. be at least 18 years of age;

b. live in the home with the beneficiary; and

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

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

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

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

§13941. Dental Services

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

1. adult diagnostic services;

2. preventative services;

3. restorative services;

4. endodontics;

5. periodontics;

6. prosthodontics;

7. oral and maxillofacial surgery;

8. orthodontics;

9. emergency care; and

10. adjunctive general services

B. Dental Service Exclusions

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

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

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

b. dental care for cosmetic reasons;

c. experimental procedures;

d. plaque control;

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

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

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

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

i. dental expenses related to any dental services:

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

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

j. administration of in-office pre-medication.

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

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

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

Chapter 141. Self-Direction Initiative

§14101. Self-Direction Service Delivery Option

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

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

1. – 2. ...

3. participation in the development and management of the approved personal purchasing plan:

a. this annual budget is determined by the recommended service hours listed in the ~~participant's~~beneficiary's CPOC to meet his/her needs;

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

C. ...

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

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

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

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

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

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

C.2.d.i. – D. ...

E. All services must be documented in service notes, which describes the services rendered and progress towards the ~~participant's~~beneficiary's personal outcomes and his/her comprehensive plan of care.

F. Service Limits

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

2. Legally responsible individuals may only be paid for services when the care is extraordinary care in comparison to that of a beneficiary of the same age without a disability and the care is in the best interest of the beneficiary.

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1209 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1651 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:79 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:58 (January 2018) LR 48:

Chapter 142. Provider Participation Requirements

§14202. Incident Reporting, Tracking and Follow-Up

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

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:58 (January 2018), amended LR 48:

Chapter 143. Reimbursement

§14301. Unit of Reimbursement

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

1. ...

2. community integration development:

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

2.b. – 4. ...

5. individual and family support-day and night:

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

5.b. – 6. ...

7. skilled nursing services:

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

b. – c. ...

8. supported employment~~, one-to-one intensive and mobile crew/enclave~~;

9. – 10. ...

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

1. – 3. ...

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

1. – 2. ...

3. ~~supported employment-follow along~~adult companion care;

4. ~~adult companion care~~individual and family support supplemental payments; and

5. ~~individual and family support supplemental payment~~monitored in-home caregiving services.

D. – F.4.a. ...

G. Payments to legally responsible individuals, legal guardians, and family members living in the home shall be audited on a semi-annual basis to ensure payment for services rendered.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1209 (June 2004), amended by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 34:252 (February 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 35:1851 (September 2009), LR 36:1247 (June 2010), LR 37:2158 (July 2011), LR 39:1049 (April 2013), LR 40:80 (January 2014), LR 42:898 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:58 (January 2018), LR 45:44 (January 2019), LR 46:1682 (December 2020), LR 48:41 (January 2022), LR 48:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services

(CMS), if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have a positive impact on family functioning, stability and autonomy as described in R.S. 49:972, since assures access to dental services and additional care options for New Opportunities Waiver beneficiaries.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have a positive impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973 as it assures access to dental services and additional care options for New Opportunities Waiver beneficiaries.

Small Business Analysis

In compliance with the Small Business Protection Act, the economic impact of this proposed Rule on small businesses has been considered. It is anticipated that this proposed Rule may have a positive impact on small businesses, as described in R.S.

49:978.1 et seq. since it provides reimbursement for services that were not previously covered.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, but may reduce the total direct and indirect cost to the provider to provide the same level of service, and may enhance the provider's ability to provide the same level of service as described in HCR 170 since this proposed Rule provides reimbursement for services that were not previously covered.

Public Comments

Interested persons may submit written comments to Patrick Gillies, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821–9030. Mr. Gillies is responsible for responding to inquiries regarding this proposed Rule. The deadline for submitting written comments is at 4:30 p.m. on April 29, 2022.

Public Hearing

Interested persons may submit a written request to conduct a public hearing by U.S. mail to the Office of the Secretary

ATTN: LDH Rulemaking Coordinator, Post Office Box 629, Baton Rouge, LA 70821-0629; however, such request must be received no later than 4:30 p.m. on April 11, 2022. If the criteria set forth in R.S. 49:953(A)(2)(a) are satisfied, LDH will conduct a public hearing at 9:30 a.m. on April 28, 2022 in Room 118 of the Bienville Building, which is located at 628 North Fourth Street, Baton Rouge, LA. To confirm whether or not a public hearing will be held, interested persons should first call Allen Enger at (225) 342-1342 after April 11, 2022. If a public hearing is to be held, all interested persons are invited to attend and present data, views, comments, or arguments, orally or in writing. In the event of a hearing, parking is available to the public in the Galvez Parking Garage, which is located between North Sixth and North Fifth/North and Main Streets (cater-corner from the Bienville Building). Validated parking for the Galvez Garage may be available to public hearing attendees when the parking ticket is presented to LDH staff at the hearing.

Dr. Courtney N. Phillips

Secretary