NOTICE OF INTENT

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

Home and Community-Based Services Waivers
Residential Options Waiver
Dental Services
(LAC 50:XXI.Chapters 161-169)

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities propose to amend LAC 50:XXI.Chapters 161-169 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 Residential Options 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 Residential Options Waiver under certain

conditions including allowing family members as paid caregivers and shared services.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community-Based Services Waivers
Subpart 13. Residential Options Waiver

Chapter 161. General Provisions

§16101. Introduction

A. The Residential Options Waiver (ROW), a 1915(c) home and community-based services (HCBS) waiver, is designed to assist beneficiaries in leading healthy, independent and productive lives to the fullest extent possible and promote the full exercise of their rights as citizens of the state of Louisiana. The ROW is person-centered incorporating the beneficiary’s support needs and preferences with a goal of integrating the beneficiary into their community. The ROW provides opportunities for eligible individuals with developmental disabilities to receive HCBS services that allow them to transition to and/or remain in the community. These individuals would otherwise require an intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care.

B. The Residential Options Waiver services are provided with the goal of promoting independence through strengthening the beneficiary’s capacity for self-care, self-sufficiency and

community integration utilizing a wide array of services, supports and residential options. The ROW is person-centered incorporating the beneficiary’s support needs and preferences, while supporting the dignity, quality of life, and security with the goal of integrating the participant into the community.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2441 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2154 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1764 (December 2019), LR 47:1507 (October 2021), LR: 48

§16103. Program Description

A. ...

B. The ROW offers an alternative to institutional care with the objectives to:

1. promote independence for beneficiaries through the provision of services meeting the highest standards of quality and national best practices, while ensuring health and safety through a comprehensive system of beneficiary safeguards;

2. ...

3. offer access to services which would protect the health and safety of the beneficiary.

C. ROW services are accessed through a single point of entry in the human services district or authority. All waiver beneficiaries choose their support coordination and direct service provider agencies through the freedom of choice process.

1. The plan of care (POC) shall be developed using a person-centered process coordinated by the beneficiary's support coordinator. The initial POC is developed during this person-centered planning process and approved by the human services district or authority. Annual reassessments may be approved by the support coordination agency supervisor as allowed by Office for Citizens with Developmental Disabilities (OCDD) policy.

D. ...

E. The total expenditures available for each waiver beneficiary is established through an assessment of individual support needs and may not exceed the approved ICF/IID Inventory for Client and Agency Planning (ICAP) rate/ROW budget level established for that individual except as approved by the OCDD assistant secretary, deputy assistant secretary, or his/her designee to prevent institutionalization. ROW acuity/budget cap

level(s) are based upon each beneficiary’s ICAP assessment tool results and may change as the beneficiary’s needs change.

1. When the department determines that it is necessary to adjust the ICF/IID ICAP rate, each waiver beneficiary’s annual service budget may be adjusted to ensure that the beneficiary’s total available expenditures do not exceed the approved ICAP rate. A reassessment of the beneficiary’s ICAP level will be conducted to determine the most appropriate support level.

2. The average beneficiary’s expenditures for all waiver services shall not exceed the average Medicaid expenditures for ICF/IID services.

3. Beneficiaries may exceed assigned ROW acuity/budget cap level(s) to access defined additional support needs to prevent institutionalization on a case by case basis according to policy and as approved by the OCDD assistant secretary or his/her designee.

4. If it is determined that the ROW can no longer meet the beneficiary’s health and safety needs and/or support the beneficiary, the case management agency will conduct person centered discovery activities.

5. ...

F. No reimbursement for ROW services shall be made for a beneficiary who is admitted to an inpatient setting.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2441 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2154 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1764 (December 2019), LR 47:1507 (October 2021), LR 48:

§16104. Settings for Home and Community Based Services

A. ROW 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 or any superseding rule.

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

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

Citizens with Developmental Disabilities, LR 45:1764 (December 2019), amended LR 47:1508 (October 2021), LR 48:

§16105. Beneficiary Qualifications

A. – A.9. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2441 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2155 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2530 (December 2017), LR 45:1764 (December 2019), LR 47:1508 (October 2021), LR 48

§16106. Money Follows the Person Rebalancing Demonstration

A. – A.1. ...

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

1. Individuals with a developmental disability must:

a. occupy a licensed, approved Medicaid enrolled nursing facility, hospital or ICF/IID bed for at least 60 days; and

b. ...

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

C. – D. ...

Person Rebalancing Demonstration.

E. MFP beneficiaries cannot participate in ROW shared living services which serve more than four persons in a single residence.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2155 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1508 (October 2021), LR 48:

§16109. Admission Denial or Discharge Criteria

A. – A.8. ...

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

1. – 6. ...

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

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

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

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

b. the beneficiary shall be discharged from the ROW if the treating physician documents that the institutional stay will exceed 90 days; or

10. continuity of services is interrupted as a result of the beneficiary not receiving ROW services during a period of 30 consecutive days.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental

Disabilities, LR 33:2443 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2156 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1765 (December 2019), LR 47:1509 (October 2021), LR 48:

Chapter 163. Covered Services

§16301. Assistive Technology and Specialized Medical Equipment and Supplies

A. Assistive technology and specialized medical equipment and supplies (AT/SMES) service includes providing specialized devices, controls, or appliances which enable a beneficiary to increase his/her ability to perform activities of daily living, ensure safety, and/or to perceive, control, and communicate within his/her environment.

1. – 1.c. ...

d. items that will increase, maintain, or improve ability of the beneficiary to function more independently in the home and/or community; and

e. ...

2. This service also includes medically necessary durable and non-durable equipment not available under the Medicaid State Plan and repairs to such items and equipment

necessary to increase/maintain the independence and well-being of the beneficiary.

2.a. – 3. ...

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

1. the evaluation of assistive technology needs of a beneficiary including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the beneficiary in the customary environment of the beneficiary;

2. – 3. ...

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

5. training or technical assistance, on the use for the beneficiary, or where appropriate, family members, guardians, advocates, authorized representatives of the beneficiary, professionals, or others;

6. – 7.a. ...

8. services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for beneficiaries.

C. Approval of AT/SMES services through ROW is contingent upon the denial of a prior authorization request for the item as a Medicaid State Plan service and demonstration of the direct medical, habilitative, or remedial benefit of the item to the beneficiary.

C.1. - D. ...

E. Service Exclusions

1. Assistive technology devices and specialized equipment and supplies that are of general utility or maintenance and items that are not of direct medical or remedial benefit to the beneficiary are excluded from coverage.

2. – 3. ...

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

1. – 2.b. ...

3. Upon completion of the work and prior to payment, the provider shall give the beneficiary a certificate of warranty for all labor and installation and all warranty certificates.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental

Disabilities, LR 33:2443 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2156 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1509 (October 2021), LR 48:

§16303. Community Living Supports

A. Community living supports (CLS) are provided to a beneficiary in his/her own home and in the community to achieve and/or to maintain the outcomes of increased independence, productivity, and enhanced family functioning, to provide relief of the caregiver, and to provide for inclusion in the community. Community living supports may be a self-directed service.

B. Community living supports focus on the achievement of one or more goals as indicated in the beneficiary’s approved plan of care by incorporating teaching and support strategies. Supports provided are related to the acquisition, improvement, and maintenance of independence, autonomy and adaptive skills. These skills include:

1. – 4. ...

C. Place of Service. CLS services are furnished to adults and children who live in a home that is leased or owned by the beneficiary or his/her family. Services may be provided in the

home or community, with the place of residence as the primary setting.

D. Community living supports may be shared by up to three beneficiaries who may or may not live together, and who have a common direct service provider agency. In order for CLS services to be shared, the following conditions must be met.

1. An agreement must be reached among all of the involved beneficiaries, or their legal guardians, regarding the provisions of shared CLS services. If the person has a legal guardian, their approval must also be obtained. In addition, CLS direct support staff may be shared across the Children's Choice or New Opportunities Waiver at the same time.

2. The health and welfare must be assured for each beneficiary.

3. Each beneficiary's plan of care must reflect shared services and include the shared rate for the service indicated.

4. – 5. ...

E. Service Exclusions

1. ...

2. Payment does not include room and board or the maintenance, upkeep, and improvement of the provider's or family's residence.

3. Community living supports may not be provided in a licensed respite care facility.

4. Community living supports services are not available to beneficiaries receiving any of the following services:

a. shared living;

b. host home; or

c. companion care.

5. Community living supports may not be billed at the same time on the same day as:

a. day habitation;

b. prevocational services;

c. supported employment;

d. respite care services-out of home;

e. transportation-community access;

f. monitored in-home caregiving (MIHC); or

g. adult day health care.

6. – 9.d. Repealed.

F. ...

1. Family members who provide CLS services must meet the same standards as providers 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. Legally responsible individuals (such as a parent or spouse) and legal guardians may provide community living supports services for a beneficiary provided that the care is extraordinary 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.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2443 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2157 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1765 (December 2019), LR 47:1510 (October 2021), LR 48:

§16305. Companion Care

A. Companion care services provide supports to assist the beneficiary in achieving and/or maintaining increased independence, productivity and community inclusion as identified in the beneficiary's plan of care. These services are designed for individuals who live independently and can manage their own household with limited supports. The companion provides personal

care and supportive services to a beneficiary who resides as a roommate with his/her caregiver. This service includes:

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

2. ...

B. Companion care services can be arranged by licensed providers who hire companions. The beneficiary must be able to self-direct services to companion. The companion is a principal care provider who is at least 18 years of age, who lives with the beneficiary as a roommate, and provides services in the beneficiary’s home. The companion is a contracted employee of the provider agency and is paid as such by the provider.

C. Provider Responsibilities

1. The provider organization shall develop a written agreement that defines all of the shared responsibilities between the companion and the beneficiary. This agreement becomes a part of the beneficiary’s plan of care. The written agreement shall include, but is not limited to:

a. – c. ...

2. Revisions to this agreement must be facilitated by the provider and approved as part of the plan of care following the same process as would any revision to a plan of care. Revisions can be initiated by the beneficiary, the

companion, the provider, or a member of the beneficiary’s support team.

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

a. ...

b. conducting an initial inspection of the beneficiary’s home with on-going periodic inspections of a frequency determined by the provider;

c. making contact with the companion at a minimum of once per week, or more often as specified in the beneficiary’s plan of care; and

d. ...

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

D. Responsibilities of the companion include:

1. – 4. ...

5. participating in and following the beneficiary’s plan of care and any support plans;

6. ...

7. being available in accordance with a pre-arranged time schedule as outlined in the beneficiary’s plan of care;

8. ...

9. being available 24 hours a day (by phone contact) to the beneficiary to provide supports on short notice as a need arises.

E. – E.1. ...

F. Service Exclusions

1. - 1.e. ...

2. Companion care services are not available to beneficiaries under the age of 18.

3. Legally responsible individuals and legal guardians may provide companion care services for a relative who beneficiary provided that the care is extraordinary 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.

a. – c. Repealed.

4. Payment does not include room and board or maintenance, upkeep, and improvement of the beneficiaries or provider’s property.

F.5. - 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 for Citizens with Developmental Disabilities, LR 33:2444 (November 2007), amended by the

Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2158 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1765 (December 2019), LR 47:1511 (October 2021), LR 48:

§16307. Day Habilitation Services

A. Day habilitation is services that assist the beneficiary to gain desired community living experience, including the acquisition, retention, or improvement in self-help, socialization, and adaptive skills, and/or to provide the beneficiary an opportunity to contribute to his or her community. These services shall be coordinated with any physical, occupational, or speech therapies identified in the individualized plan of care. Day habilitation services may include assistance with personal care or with activities of daily living, but such assistance should not be the primary activity. Day habilitation services may serve to reinforce skills or lessons taught in other settings. Volunteer activities may be a part of this service and should follow the state guidelines for volunteering.

1. – 3. Repealed.

B. Day habilitation may be delivered in a combination of these three service types:

1. onsite day habilitation;

2. community life engagement; and

3. virtual day habilitation.

a. – d. Repealed.

C. Day habilitation services are provided on a regularly scheduled basis for one or more days per week in a variety of community settings that are separate from the beneficiary's private residence, with the exception of virtual day habilitation. Day habilitation services should not be limited to a fixed site facility. Activities and environments are designed to foster personal choice in developing the beneficiary's meaningful day including community activities alongside people who do not receive home and community-based services.

1. – 2. Repealed.

D. The day habilitation provider is responsible for all transportation between day habilitation sites and while providing community life engagement services in the community.

1. Transportation can only be billed on the day that an in-person day habilitation service is provided.

2. Transportation is not a part of the service for virtual day habilitation.

E. Beneficiaries receiving day habilitation services may also receive prevocational and/or individual supported

employment services on the same day, but these services cannot be provided during the same time period or total more than five hours per day combined.

1. – 3.g. Repealed.

F. Service Exclusions

1. Time spent in transportation between the beneficiary's residence/location and the day habilitation site is not to be included in the total number of day habilitation service hours per day, except when the transportation is for the purpose of travel training.

a. Travel training for the purpose of teaching the beneficiary to use transportation services may be included in determining the total number of service hours provided per day. Travel training must be included in the beneficiary's plan of care.

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

3. Day habilitation services cannot be billed for at the same time on the same day as:

a. community living supports;

b. professional services, except when there are direct contacts needed in the development of a support plan;

c. respite—out of home;

d. adult day health care;

e. monitored in-home caregiving (MIHC);

f. prevocational services; or

g. supported employment.

4. Day habilitation services shall be furnished on a regularly scheduled basis for up to eight hours per day, one or more days per week.

a. Services are based on a 15 minute unit of service and on time spent at the service site by the beneficiary. Any time less than 15 minutes of service is not billable or payable. No rounding up of units is allowed.

b. Services are based on the person centered plan and the beneficiary's ROW budget.

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

6. Day Habilitation may not provide for the payment of services that are vocational in nature – for example, the primary purpose of producing goods or performing services.

G. Provider Qualifications. Providers must be licensed by the Department of Health as a home and community-based services provider and meet the module requirements for adult day care in LAC 48:I.Chapter 50.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2445 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2158 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1765 (December 2019), LR 47:1512 (October 2021), LR 48:

§16309. Dental Services

A. Dental services are available to adult beneficiaries over the age of 21 as of component of the ROW. 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. ROW dental services are not available to children (up to 21 years of age). Children access dental services through the EPSDT benefit.

2. services must first be exhausted prior to accessing ROW dental services. 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 services; and

j. Administration of in-office pre-medication.

C. Provider Qualifications. 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 and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2445 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2159 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1512 (October 2021), LR 48:

§16311. Environmental Accessibility Adaptations

A. Environmental accessibility adaptations are physical adaptations to the beneficiary's home or vehicle which are

necessary to ensure health, welfare, and safety of the beneficiary, or which enable the beneficiary to function with greater independence, without which the beneficiary would require additional supports or institutionalization. Environmental adaptations must be specified in the beneficiary's plan of care.

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

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

1. ...

2. training the beneficiary and the provider in the use and maintenance of the environmental adaptation(s);

3. – 4. ...

C. Home adaptations which pertain to modifications that are made to a beneficiary's primary residence. Such adaptations to the home may include bathroom modifications, ramps, or other adaptations to make the home accessible to the beneficiary.

1. ...

2. The service may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment

and supplies which are necessary for the welfare of the beneficiary.

D. – F.3.a. ...

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

4.a. – 5. ...

G. Vehicle adaptations pertain to modifications to a vehicle that is the waiver beneficiary’s primary means of transportation in order to accommodate his/her special needs.

1. Such adaptations to the vehicle may include a lift, or other adaptations, to make the vehicle accessible to the participant or for the beneficiary to drive.

G.2. – H.1.b. ...

2. Vehicle modification funds may not be used for modifications which are of general utility and are not of direct medical or remedial benefit to the beneficiary.

H.3. – I.3. ...

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

J. – J.4. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2446 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2159 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1513 (October 2021), LR 48:

§16313. Host Home

A. Host home services are personal care and supportive services provided to a beneficiary who lives in a private home with a family who is not the beneficiary's parent, legal representative, or spouse. Host home families are a stand-alone family living arrangement in which the principle caregiver in the host home assumes the direct responsibility for the beneficiary's physical, social, and emotional well-being and growth in a family environment. Host home services are to take into account compatibility with the host home family members, including age, support needs, and privacy needs.

B. – B.4. ...

NOTE: Natural supports are also encouraged and supported when possible. Supports are to be consistent with the beneficiary’s skill level, goals, and interests.

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

1. ...

2. making an initial inspection and periodic inspections of the host home and upon any significant changes in the host family unit or significant events which may impact the beneficiary;

3. having 24-hour responsibility over host home services to the beneficiary, which includes back-up staffing for scheduled and unscheduled absences of the host home family for up to 360 hours (15 days) as authorized by the beneficiary’s plan of care; and

4. providing relief staffing in the beneficiary’s home or in another host home family's home.

D. Host home contractors are responsible for:

1. attending the beneficiary’s plan of care meeting and participating, including providing information needed in the development of the plan;

2. following all aspects of the beneficiary’s plan of care and any support plans;

3. maintaining the beneficiary’s documentation;

4. assisting the beneficiary in attending appointments (i.e., medical, therapy, etc.) and undergoing any specialized training deemed necessary by the provider agency, or required by the department, to provide supports in the host home setting;

5. following all requirements for staff as in any other waiver service including immediately reporting to the department and applicable authorities any major issues or concerns related to the beneficiary’s safety and well-being; and

D.6. – E. ...

1. If the beneficiary is a child, the host home family is to provide the supports required to meet the needs of a child as any family would for a minor child.

2. ...

3. A host home family can provide compensated supports for up to two beneficiaries, regardless of the funding source

F. Host home contractors serving adults are required to be available for daily supervision, support needs or emergencies as outlined in the adult beneficiary’s POC based on medical,

health and behavioral needs, age, capabilities and any special needs.

1. ...

G. Host home contractors who are engaged in employment outside the home must adjust these duties to allow the flexibility needed to meet their responsibilities to the beneficiary.

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

I. – I.3. ...

4. Payment will not be made for services provided by a relative who is a:

a. – c. ...

d. spouse of the beneficiary.

5. – 6. ...

7. Environmental adaptations are not available to beneficiaries receiving host home services since the beneficiary’s place of residence is owned or leased by the host home family.

J. – J.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 for Citizens with Developmental Disabilities, LR 33:2447 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2160 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1765 (December 2019), LR 47:1514 (October 2021), LR 48:

§16317. Nursing Services

A. ...

1. Nursing services must be included in the beneficiary’s plan of care and must have the following:

a. – g. ...

2. The beneficiary’s nurse must submit updates every 60 days and include any changes to the beneficiary’s needs and/or physician's orders.

B. Consultations include assessments, health related training/education for the beneficiary and the beneficiary’s caregivers, and healthcare needs related to prevention and primary care activities.

1. – 2. ...

3. Health related training and education service is the only nursing procedure which can be provided to more than one beneficiary simultaneously.

C. – C.1. ...

D. Service Requirements

1. Nursing services are secondary to EPSDT services for beneficiaries under the age of 21 years. Beneficiaries under the age of 21 have access to nursing services (home health and extended care) under the Medicaid State Plan.

2. Adults have access only to home health nursing services under the Medicaid State Plan. Beneficiaries must access and exhaust all available Medicaid State Plan services prior to accessing ROW nursing services.

E. – F.4.b. ...

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2449 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2161 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1515 (October 2021), LR 48:

§16319. One Time Transitional Services

A. One-time transitional services are non-reoccurring set-up expenses to assist a beneficiary who is moving from an institutional setting to his or her own home. The beneficiary's support coordinator assists in accessing funds and making arrangements in preparation for moving into the residence.

B. – B.5. ...

C. Service Limits

1. There is a one-time, lifetime maximum services cap of $3,000 per beneficiary.

C.2. – D.1.b. ...

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

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

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 for Citizens with Developmental Disabilities, LR 33:2449 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2162 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and

the Office for Citizens with Developmental Disabilities, LR 45:1766 (December 2019), LR 47:1516 (October 2021), LR 48:

§16321. Personal Emergency Response System (PERS)

A. Personal emergency response system (PERS) service is an electronic device connected to the beneficiary's phone that enables him or her to secure help in an emergency. The service also includes an option in which the beneficiary would wear a portable help button. The device is programmed to emit a signal to the PERS response center where trained professionals respond to the beneficiary's emergency situation.

B. Beneficiary Qualifications. PERS service is most appropriate for beneficiaries who:

1. – 2. ...

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 beneficiary to use the equipment.

D. Service Exclusions

1. ...

2. PERS services are not available to beneficiaries who receive 24-hour direct care supports.

E. Provider Qualifications

1. ...

3. Providers must meet manufacturer’s specifications, response requirements, maintenance records, and enrollee education.

4. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2249 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2162 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1516 (October 2021), LR 48:

§16323. Prevocational Services

A. Prevocational services are individualized, person centered services that assist beneficiaries in establishing their path to obtain individualized community employment. This service is time limited and targeted for people who have an interest in becoming employed in individual jobs in the community but who 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.

B. Prevocational services may be delivered in a combination of these three service types:

1. onsite prevocational services;

2. community career planning; and

3. virtual prevocational services.

4. – 4.c. Repealed.

C. 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.

1. – 2. Repealed.

D. Beneficiaries receiving prevocational services must participate in activities designed to establish an employment goal. 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. Prevocational services may include assistance with personal care or with activities of daily living.

1. – 3. Repealed.

E. The prevocational provider is responsible for all transportation between prevocational sites. Transportation may be provided between the beneficiary's residence, or other location as agreed upon by the beneficiary or authorized representative, and the prevocational site. The beneficiary's transportation needs shall be documented in the plan of care.

F. Service Limitations

1. Service limits shall be based on the person centered plan and the beneficiary's ROW budget. Services are delivered in a 15-minute unit of service for up to eight hours per day, one or more days per week. The 15-minute unit of service must be spent at the service site by the beneficiary.

a. – b. ...

2. Prevocational services are not available to individuals 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 those covered under the state plan, if applicable.

3. Prevocational services cannot be billed for at the same time on the same day as other ROW services.

a. – g. ...

4. Prevocational services may otherwise be billed at the same time on the same day as professional services when there are direct contacts needed in the development of a support plan.

a. – c. Repealed.

5. Transportation is only provided on the day that a prevocational service is provided. Transportation is part of the service except for virtual prevocational services.

a. Time spent in transportation between the beneficiary's residence/location and the prevocational site is not to be included in the total number of prevocational service hours per day, except when the transportation is for the purpose of travel training. Travel training must be included in the beneficiary's plan of care.

b. During travel training, providers must not also bill for the transportation component as this is included in the rate for the number of service hours provided.

c. Transportation-community access services shall not be used for transportation to or from any prevocational services.

G. Restrictions

1. Beneficiaries receiving prevocational services may also receive day habilitation and/or individualized

supported employment services, but these services cannot be provided during the same time period or total more than five hours per day combined.

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

3. Repealed.

H. Provider Qualifications. Providers must be licensed by the Department of Health as a home and community-based services provider and meet the module requirements for adult day care in. LAC 48:I.Chapter 50.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2450 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2162 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1766 (December 2019), LR 47:1516 (October 2021), LR 48:

§16325. Professional Services

A. Professional services are direct services to beneficiaries based on the beneficiary's need, which assist the beneficiary, unpaid caregivers, and/or paid caregivers in carrying out the beneficiary's approved plan and which are necessary to improve the beneficiary's independence and inclusion in his/her community. The beneficiary must be present in order for the professional to bill for services. Professional services include nutritional services, speech therapy, occupational therapy, physical therapy, social work, and psychological services. All services are to be included in the beneficiary's plan of care. The specific service provided to a beneficiary must be within the professional's area of specialty and licensing.

B. – B.6 ...

C. Professional services can include:

1. ...

2. providing training to the beneficiary, family, and caregivers with the goal of increased skill acquisition and proficiency;

3. – 4. ...

5. providing information to the beneficiary, family, and caregivers, along with other support team members, to assist in planning, developing, and implementing a beneficiary's plan of care;

6. – 7.a. ...

8. providing therapy to the beneficiary necessary to the development of critical skills; and

9. assistance in increasing independence, participation, and productivity in the beneficiary home, work, and/or community environments.

***

D. Service Exclusions

1. Private insurance must be billed and exhausted prior to accessing waiver funds. Professional services may only be furnished and reimbursed through ROW when the services are medically necessary, or have habilitative or remedial benefit to the beneficiary.

D.2. – E.4.b. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2450 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2163 (October 2015), by the Department of Health, Bureau of Health Services Financing and the Office for

Citizens with Developmental Disabilities, amended LR 47:1518 (October 2021), LR 48:

§16327. Respite Care Services–Out of Home

A. Respite care services–out of home are provided on a short-term basis to beneficiaries who are unable to care for themselves due to the absence of, or need for, relief of caregivers who normally provide care and support. Services are provided by a center-based respite provider.

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

2. While receiving respite care services, the beneficiary's routine is maintained in order to attend school, school activities or other community activities. Community activities and transportation to and from these activities in which the beneficiary typically engages in are to be available while receiving respite services-out of home.

a. These activities should be included in the beneficiary's approved plan of care. This will provide the beneficiary the opportunity to continue to participate in typical routine activities.

b. ...

B. Service Limits

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

2. – 3. ...

C. Service Exclusions

1. ...

2. Respite care services-out of home is not a billable waiver service to beneficiary receiving the following services:

C.2.a. – 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 for Citizens with Developmental Disabilities, LR 33:2451 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2164 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1767 (December 2019), LR 47:1519 (October 2021), LR 48:

§16329. Shared Living Services

A. Shared living services are provided to a beneficiary in his/her home and community to achieve, improve, and/or maintain social and adaptive skills necessary to enable the

beneficiary to reside in the community and to participate as independently as possible. Services are chosen by the beneficiary and developed in accordance with his/her goals and wishes with regard to compatibility, interests, age and privacy in the shared living setting.

1. A shared living services provider delivers supports which include:

a. ...

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

c. – f. ...

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

2. Shared living services focus on the beneficiary's preferences and goals.

3. Supports provided are related to the acquisition, improvement, and maintenance in level of independence, autonomy, and adaptive skills and are to be included in each beneficiary's plan of care. This includes:

a. – c. ...

4. The overall goal is to provide the beneficiary the ability to successfully reside with others in the community while sharing supports.

5. Shared living services take into account the compatibility of the beneficiaries sharing services, which includes individual interests, age of the beneficiaries, and the privacy needs of each beneficiary.

a. Each beneficiary's essential personal rights of privacy, dignity and respect, and freedom from coercion are protected.

6. The shared living setting is selected by each beneficiary among all available alternatives and is identified in each beneficiary's plan of care.

a. Each beneficiary has the ability to determine whether or with whom he or she shares a room.

b. Each beneficiary has the freedom of choice regarding daily living experiences, which include meals, visitors, and activities.

c. Each beneficiary is not limited in opportunities to pursue community activities.

7. Shared living services may be shared by up to four beneficiaries who have a common shared living provider agency.

8. Shared living services must be agreed to by each beneficiary and the health and welfare must be able to be assured for each beneficiary.

a. ...

b. Each beneficiary’s plan of care must reflect the shared living services and include the shared rate for the service indicated.

9. The shared living service setting is integrated in, and facilitates each beneficiary’s full access to, the greater community, which includes providing beneficiaries with the same opportunities as individuals without disabilities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community.

B. – B.3. ...

4. All shared living service beneficiaries are required to have an individualized back-up staffing plan and an individualized emergency evacuation plan which are to be submitted with their plan of care.

5. – 6. ...

7. Shared living service providers are responsible for providing 24-hour staff availability along with other identified responsibilities as indicated in each beneficiary’s individualized plan of care. This includes responsibility for each beneficiary’s routine daily schedule, for ensuring the health and welfare of each beneficiary while in his or her place of residence and in the community, and for any other waiver services provided by the shared living services provider.

8. Shared living services may be provided in a residence that is owned or leased by the provider or that is owned or leased by the beneficiary. Services may not be provided in a residence that is owned or leased by any legally responsible relative of the beneficiary. If shared living services are provided in a residence that is owned or leased by the provider, any modification of the conditions must be supported by specific assessed needs and documented in the beneficiary's plan of care. The provider is responsible for the cost of, and implementation of, the modification when the residence is owned or leased by the provider.

9. In a provider-owned or controlled residential setting, the following additional conditions must be met. Any modifications of the conditions must be supported by a specific assessed need and documented in the plan of care:

a. the unit or room is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the beneficiary receiving services, and the beneficiary has, at a minimum, the same responsibilities and protections from eviction that the tenants have under the landlord/tenant laws of the state, parish, city, or other designated entity;

b. each beneficiary has privacy in their sleeping or living unit, which requires the following:

i. ...

ii. beneficiaries share units only at the beneficiary’s choice; and

iii. beneficiaries have the freedom to furnish and decorate their sleeping or living units;

c. beneficiaries have the freedom and support to control their own schedules and activities, and have access to food at any time;

d. beneficiaries are able to have visitors of their choosing at any time; and

e. the setting is physically accessible to the beneficiary.

C. Shared Living Options

1. ...

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

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

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

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

2. – 2.a. ...

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

c. ...

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

3. ICF/IID providers who convert an ICF/IID to a shared living home via the shared living conversion model must be approved by OCDD and licensed by HSS prior to providing services in this setting, and prior to accepting any ROW beneficiary or applicant for residential or any other developmental disability service(s).

4. – 5. ...

D. Service Exclusions and Limitations

1. Payment does not include room and board or maintenance, upkeep or improvements of the beneficiary's or the provider's property.

2. ...

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

4. MFP beneficiaries cannot participate in ROW shared living services which serve more than four persons in a single residence.

5. Transportation-community access services cannot be billed or provided for beneficiaries receiving shared living services, as this is a component of shared living services.

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

a. – g. ...

7. Shared living services are not available to beneficiary 17 years of age and under.

8. – 9 ...

10. Payment will not be made for services provided by a relative who is a:

a. – c. ...

d. spouse of the beneficiary.

11. The shared living staff may not live in the beneficiary’s place of residence.

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 for Citizens with Developmental Disabilities, LR 33:2452 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2164 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1767 (December 2019), LR 47:1519 (October 2021), LR 48:

§16333. Support Coordination

A. Support coordination services are provided to all beneficiaries to provide assistance in gaining access to needed waiver services and Medicaid State Plan services, as well as needed medical, social, education, and other services, regardless of the funding source for the services. Support coordination services include assistance with the selection of service providers, development/revision of the plan of care, and monitoring of services.

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

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

3. Support coordination services includes on-going support and assistance to the beneficiary.

B. When beneficiaries choose to self-direct their waiver services, the support shall provide information, assistance, and management of the service being self-directed.

C. Service Limits

1. Support coordination shall not exceed 12 units. A calendar month is a unit. Virtual visits are permitted; however, the initial and annual plan of care meeting and at least one other meeting per year must be conducted face-to-face. When a relative living in the home or a legally responsible individual or legal guardian provides a paid ROW service, all support coordination visits must be conducted face-to-face, with no option for virtual visits.

C.2. – 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 for Citizens with Developmental

Disabilities, LR 33:2453 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2165 (October 2015), by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, amended LR 47:1521 (October 2021), LR 48:

§16335. Supported Employment

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

1. – 2. Repealed.

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

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

2. job assessment, discovery, and development; and

a. – d. Repealed.

3. initial job support and job retention.

4. Repealed.

C. When supported employment services are provided at a work site where a majority of the persons employed are without disabilities, payment is made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, but payment will not be made for the supervisory activities rendered as a normal part of the business setting.

D. The provider is responsible for all transportation to all work sites related to the provision of services in group employment. Transportation to and from the service site is offered and billable as a component of the supported employment service.

1. ...

2. Time spent in transportation to and from the program shall not be included in the total number of supported employment services hours provided per day.

E. These services are also available to those beneficiaries who are self-employed. Funds for self-employment may not be used to defray any expenses associated with setting up or operating a business.

F. – F.2. ...

G. Service Limits. Beneficiaries may receive more than one type of vocational or habilitation service per day as long

as the billing criteria is followed and as long as the requirements for the minimum time spent on site are adhered to. The required minimum number of service hours per day, per beneficiary are as follows:

1. Individual supported employment services - one hour (four units). One-on-one services shall be billed in quarterly hour units and shall be based on the person centered plan and the beneficiary’s ROW budget.

2. Services that assist a beneficiary to develop and operate a micro-enterprise - one hour (four units). One-on-one services shall be billed in quarterly hour units and shall be based on the person centered plan and the beneficiary’s ROW budget.

3. Group employment services shall be billed in quarterly hour units of service up to eight hours per day and shall be based on the person centered plan and the beneficiary’s ROW budget.

4. Individual job follow-along services may be delivered virtually.

H. Service Exclusions and Restrictions. Beneficiaries receiving individual supported employment services may also receive prevocational, day habilitation, or group supported employment services. However, these services cannot be provided during the same service hours on the same day.

1. ...

2. Supportive employment cannot be billed for the same time as any other ROW services.

a. –e. Repealed.

3. Any time less than the minimum 15 minute unit of service is provided for any model is not billable or payable. No rounding up of service units is allowed.

4. ...

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

b. ...

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

a. – c. Repealed.

6. Supported employment services are not available to individuals who are eligible to participate in services that are available from programs funded under section 110 of the Rehabilitation Act of 1973 or sections 602(16) or (17) of the Individuals with Disabilities Education Act [20 U.S.C. 1401 (26) and (29)] and those covered under the state plan, if applicable.

7. – 8. Repealed.

I. Provider Qualifications. The provider must possess a valid certificate of compliance as a community rehabilitation provider (CRP) from an approved program or the certification and training as required.

1. – 2. 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 for Citizens with Developmental Disabilities, LR 33:2453 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2166 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1767 (December 2019), LR 47:1521 (October 2021), LR 48:

§16337. Transportation-Community Access

A. Transportation-community access services are provided to assist the beneficiary in becoming involved in his or her community. The service encourages and fosters the developmental of meaningful relationships in the community which reflects the beneficiary’s choice and values. This service provides the beneficiary with a means of access to community activities and resources. The goal is to increase the beneficiary’s

independence, productivity, and community inclusion and to support self-directed employees benefits as outlined in the beneficiary’s POC.

1. Transportation-community access services are to be included in the beneficiary’s plan of care.

2. The beneficiary must be present for the service to be billed.

3. Prior to accessing transportation-community access services, the beneficiary is to utilize free transportation provided by family, friends, and community agencies.

4. When appropriate, the beneficiary should access public transportation or the most cost-effective method of transportation prior to accessing transportation-community access services.

B. – C.1.c. ...

2. Transportation-community access services are not available to beneficiaries receiving the following services:

a. – c. ...

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

4. ...

D. Provider Qualifications. Friends and family members who furnish transportation-community access services to waiver beneficiaries must be enrolled as Medicaid non-emergency medical transportation (NEMT) family and friends providers with the Department of Health (Bureau of Health Services Financing).

1. – 3.a. ...

4. NEMT (family and friends transportation) providers may provide for up to three identified waiver beneficiaries.

E. Vehicle Requirements. All vehicles utilized by for profit and non-profit transportation services providers for transporting waiver beneficiaries must comply with all of the applicable state laws and regulations and are subject to inspection by the department or its designee.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2454 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2166 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and

the Office for Citizens with Developmental Disabilities, LR 45:1768 (December 2019), LR 47:1523 (October 2021), LR 48:

§16339. Housing Stabilization Transition Services

A. Housing stabilization transition services enable beneficiaries who are transitioning into a permanent supportive housing unit, including those transitioning from institutions, to secure their own housing. This service is provided while the beneficiary is in an institution and preparing to exit the institution using the waiver. The service includes the following components:

1. conducting a housing assessment to identify the 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. assisting a beneficiary to view and secure housing, as needed. This may include the following:

a. – e. ...

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

a. ...

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

3.c. – 5. ...

B. This service is only available to beneficiaries upon referral from the support coordinator, and is not duplicative of other waiver services, including support coordination.

1. beneficiaries must be residing in a state of Louisiana permanent supportive housing unit; or

2. beneficiaries must be linked for the state of Louisiana permanent supportive housing selection process.

C. Beneficiaries are limited to receiving no more than 165 combined units of this service and the housing stabilization transition service. This limit on combined units can only be exceeded with written approval from OCDD.

D. – D.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, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2169 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1523 (October 2021), LR 48:

§16341. Housing Stabilization Services

A. Housing stabilization services enable waiver beneficiaries to maintain their own housing as set forth in the

approved plan of care. Services must be provided in the home or a community setting. Housing stabilization services include the following components:

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

a. – h. ...

2. assisting a beneficiary to view and secure housing, as needed and may include the following:

a. – e. ...

3. developing an individualized housing stabilization service provider plan, based upon the housing assessment, that:

a. ...

b. establishes the beneficiary’s approach to meeting the goal; and

3.c. -. 5. ...

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

a. the beneficiary’s disability;

b. – c. ...

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

B. ...

1. Beneficiaries must be residing in a state of Louisiana permanent supportive housing unit; or

2. beneficiaries must be linked for the state of Louisiana permanent supportive housing selection process.

C. Beneficiaries are limited to receiving no more than 165 combined units of this service and the housing stabilization transition service. This limit on combined units can only be exceeded with written approval from OCDD.

D. – D.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, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2170 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1524 (October 2021), LR 48:

§16343. Adult Day Health Care Services

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

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

1. ...

2. transportation between the beneficiary's place of residence and the ADHC (if the beneficiary is accompanied by the ADHC staff) in accordance with licensing standards;

3. – 9. ...

C. The number of people included in the service per day depends on the licensed capacity and attendance at each facility. The average capacity per facility is 49beneficiaries.

D. Nurses shall be involved in the beneficiary's service delivery as specified in the plan of care (POC) or as needed. Each beneficiary has a plan of care from which the ADHC shall develop an individualized service plan based on the beneficiary's POC. If the individualized service plan calls for certain health and nursing services, the nurse on staff shall

ensure that the services are delivered while the beneficiary is at the ADHC facility.

E. G.4. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 42:62 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1768 (December 2019), LR 47:1524 (October 2021), LR 48:

§16345. Monitored In-Home Caregiving Services

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

1. ...

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 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. – 2. ...

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

4. – 6. ...

C. Service Exclusions and Restrictions

1. Beneficiaries electing monitored in-home caregiving are not eligible to receive the following Residential Options Waiver services during the period of time that the beneficiaries are receiving monitored in-home caregiving services:

a. – c. ...

d. shared living supports; and

e. adult day health Care services.

f. Repealed.

D. – D.2. ...

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

4. ...

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.

G. – G.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, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1768 (December 2019), amended LR 47:1525 (October 2021), LR 48:

Chapter 165. Self-Direction Initiative

§16501. Self-Direction Service Option

A. Self-direction is a service delivery option which allows beneficiaries (or their authorized representative) to exercise employer authority in the delivery of their authorized self-directed services (community living supports).

1. Beneficiaries are informed of all available services and service delivery options, including self-direction, at the time of the initial assessment, annually, or as requested by beneficiaries or their authorized representative. Beneficiaries, who are interested in self-direction, need only notify their support coordinator, who will facilitate the enrollment process.

2. A contracted fiscal/employer agent is responsible for processing the beneficiary’s employer-related payroll, withholding and depositing the required employment-related taxes, and sending payroll reports to the beneficiary or his/her authorized representative.

3. Support coordinators assist beneficiaries by providing the following activities:

a. the development of the beneficiary’s plan of care;

b. organizing the unique resources the beneficiary needs;

c. training beneficiaries on their employer responsibilities;

d. – g. ...

h. ensuring beneficiary's needs are being met through services.

B. Beneficiary Eligibility. Selection of the self-direction option is strictly voluntary. To be eligible to participate in the self-direction service option, waiver beneficiaries must:

1. – 3. ...

NOTE: If the waiver beneficiary is unable to make decisions independently, the beneficiary must have a willing decision maker (an authorized representative as listed on the beneficiary's plan of care) who understands the rights, risks, and responsibilities of managing the care and supports of the beneficiary within the plan of care.

C. Beneficiary Responsibilities. Responsibilities of the waiver beneficiary or his or her authorized representative include the following:

1. Beneficiaries must adhere to the health and welfare safeguards identified by the support team, including the following:

a. ...

b. compliance with the requirement that employees under this option must have criminal background checks prior to working with waiver beneficiaries.

2. Waiver beneficiary’s 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 beneficiary’s POC to meet his needs.

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

3. Beneficiaries are informed of the self-direction option at the time of the initial assessment, annually, or as requested by beneficiaries or their authorized representative. If the beneficiary is interested, the support coordinator will provide more information on the principles of self-determination, the services that can be self-directed, the roles and responsibilities of each service option, the benefits and risks of each service option, and the process for enrolling in self-direction.

4. Prior to enrolling in self-direction, the beneficiary or his/her authorized representative is trained by the support coordinator on the process for completing the following duties:

4.a. – 5. ...

6. Beneficiaries who choose self-direction verify that they have received the required training by signing the service agreement form.

7. Authorized representatives may be the employer in the self-directed option but may not also be the employee.

D. ...

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

a. ...

b. Should the request for voluntary withdrawal occur, the beneficiary will receive counseling and assistance from his or her support coordinator immediately upon identification of issues or concerns in any of the above situations.

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

a. the beneficiary does not receive self-directed services for 90 days or more;

b. the health, safety, or welfare of the beneficiary is compromised by continued participation in the self-direction service option;

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

d. there is misuse of public funds by the beneficiary or the authorized representative;

e. over three payment cycles in the period of a year, the beneficiary or authorized representative:

i. permits employees to work over the hours approved in the beneficiary's plan of care or allowed by the participant's program;

ii. – v. ...

f. the beneficiary or the authorized representative consistently violates Medicaid program rules or guidelines of the self-direction option.

3. When action is taken to terminate a beneficiary from self-direction involuntarily, the support coordinator immediately assists the beneficiary in accessing needed and appropriate services through the ROW and other available programs, ensuring that no lapse in necessary services occurs for which the beneficiary is eligible. There is no denial of services, only the transition to a different payment option. The

beneficiary and support coordinator are provided with a written notice explaining the reason for the action and citing the policy reference.

E. Employees of beneficiaries in the self-direction service option are not employees of the fiscal agent or the department.

1. – 1.c. ...

F. Relief coverage for scheduled or unscheduled absences, which are not classified as respite care services, can be covered by other participant-directed providers and the terms can be part of the agreement between the beneficiary and the primary companion care provider.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2455 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2167 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1525 (October 2021), LR 48:

Chapter 167. Provider Participation

§16701. General Provisions

A. – B. ...

C. In order for a provider to bill for services, the waiver beneficiary and the direct service worker or professional services practitioner rendering service must be present at the time the service is rendered.

1. Exception. The following services may be provided when the beneficiary is not present:

a. – c. ...

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

D. – E. ...

F. Some ROW services may be provided by a member of the beneficiary's family, provided that the family member meets all the requirements of a non-family direct support worker and provision of care by a family member is in the best interest of the beneficiary.

1. Payment for services rendered are approved by prior and post authorization as outlined in the POC.

2. 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.

3. – 4. Repealed.

G. – G.3.a. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2455 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2168 (October 2015), LR 42:63 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1527 (October 2021).

§16703. Staffing Restrictions and Requirements

A. Legally responsible individuals may only be paid for services when the care is extraordinary 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.

1. – 4. Repealed.

B. In order to receive payment, relatives must meet the criteria for the provision of the service and the same provider qualifications specified for the service as other providers not related to the beneficiary.

1. Relatives must also comply with the following requirements:

a. become an employee of the beneficiary's agency of choice and meet the same standards as direct support staff who are not related to the individual;

b. ...

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

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

1.c.ii. -2.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 Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2168 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1527 (October 2021), LR 48:

Chapter 169. Reimbursement

§16901. Unit of Reimbursement

A. Reimbursement for the following services shall be a prospective flat rate for each approved unit of service provided to the waiver beneficiary. One quarter hour (15 minutes) is the

standard unit of service and reimbursement shall not be made for less than one quarter hour of service. This covers both the service provision and administrative costs for these services:

1. – 4. ...

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

4.b. – 9. ...

***

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

1. ...

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

B.2. – G. ...

H. Dental Services. Dental services are reimbursed according to the LA Dental Benefit Program.

I. – J. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2456 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:1049 (April 2013), LR 41:2168, 2170 (October 2015), LR 42:63 (January 2016), LR 42:900 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2530 (December 2017), LR 45:1769 (December 2019), LR 47:1527 (October 2021), 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 or autonomy as described in R.S. 49:972 as it assures access as it assures access to dental services and additional care options for ROW 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 it assures access as it assures access to dental services and additional care options for ROW 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 it 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 31, 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

FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES

Person Preparing Statement: Veronica Dent

Dept.: Health

Phone: 342-3238

Office: Bureau of Health Services Financing

Return Address: PO Box 91030
Baton Rouge, LA

Rule Title: Home and Community-Based Services Waivers
Residential Options Waiver
Dental Services

Date Rule Takes Effect: June 20, 2022

SUMMARY
(Use complete sentences)

In accordance with Section 953 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a fiscal and economic impact statement on the rule proposed for adoption, repeal or amendment. THE FOLLOWING STATEMENTS SUMMARIZE ATTACHED WORKSHEETS, I THROUGH IV AND WILL BE PUBLISHED IN THE LOUISIANA REGISTER WITH THE PROPOSED AGENCY RULE.

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that implementation of this proposed rule will result in increased state costs of approximately $4,536 for FY 21-22, $426,309 for FY 22-23 and $468,210 for FY 23-24. It is anticipated that $9,072 ($4,536 SGF and $4,536 FED) will be expended in FY 21-22 for the state's administrative expense for promulgation of this proposed rule and the final rule.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will increase statutory dedicated revenue collections by approximately $26,339 for FY 22-23 and $35,098 for FY 23-24 In addition, it is anticipated that the implementation of this proposed rule will increase federal revenue collections by approximately $4,536 for FY 21-22, $426,309 for FY 22-23, and $468,210 for FY 22-24. It is anticipated that $4,536 will be collected in FY 21-22 for the federal share of the expense for promulgation of this proposed rule and the final rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS, SMALL BUSINESSES, OR NON-GOVERNMENTAL GROUPS (Summary)

This proposed rule, in compliance with Act 450 of the 2021 Regular Session of the Louisiana Legislature, amends the provisions governing the Residential Options Waiver (ROW) in order to add adult dental services as a covered service. In addition, it also proposes to add waiver flexibilities in the delivery of ROW services including family as paid caregiver and shared services. This proposed rule will benefit ROW beneficiaries by covering adult dental services and allowing flexibility in the delivery of services. Providers will benefit from implementation of this proposed rule as it is anticipated that it will increase payments for services by approximately $1,502,146 for FY 22-23 and $1,547,211 for FY 23-24.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
This rule has no known effect on competition and employment.

Signature of Agency Head or Designee

Evan Brasseaux, Interim Deputy Fiscal Officer
Legislative Fiscal Officer or Designee

Patrick Gillies, Medicaid Executive Director
Typed Name & Title of Agency Head or Designee

March 8, 2022
Date of Signature

3/8/22
Date of Signature

FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES

The following information is required in order to assist the Legislative Fiscal Office in its review of the fiscal and economic impact statement and to assist the appropriate legislative oversight subcommittee in its deliberation on the proposed rule.

A. Provide a brief summary of the content of the rule (if proposed for adoption, or repeal) or a brief summary of the change in the rule (if proposed for amendment). Attach a copy of the notice of intent and a copy of the rule proposed for initial adoption or repeal (or, in the case of a rule change, copies of both the current and proposed rules with amended portions indicated).

This proposed rule, in compliance with Act 450 of the 2021 Regular Session of the Louisiana Legislature, amends the provisions governing the Residential Options Waiver (ROW) in order to add adult dental services as a covered service. In addition, it also proposes to add waiver flexibilities in the delivery of ROW services including family as paid caregiver and shared services.

B. Summarize the circumstances, which require this action. If the Action is required by federal regulation, attach a copy of the applicable regulation.

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 Residential Options 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 Residential Options Waiver under certain conditions including allowing family members as paid caregivers and shared services.

C. Compliance with Act 11 of the 1986 First Extraordinary Session

(1) Will the proposed rule change result in any increase in the expenditure of funds? If so, specify amount and source of funding.

Yes. It is anticipated that implementation of this proposed rule will result in increased programmatic costs of approximately $9,072 for FY 21-22, $1,502,146 for FY 22-23, and $1,547,211 for FY 23-24. In FY 21-22, $9,072 is included for the state's administrative expense for promulgation of this proposed rule and the final rule.

(2) If the answer to (1) above is yes, has the Legislature specifically appropriated the funds necessary for the associated expenditure increase?

(a) _____ Yes. If yes, attach documentation.

(b) __X__ NO. If no, provide justification as to why this rule change should be published at this time

Act 119 of the 2021 Regular Session of the Louisiana Legislature allocated funds to the Medical Vendor Program for payments to providers and the operation of the Medicaid Program, and thereby, authorizes the expenditure of these funds. Implementation of this proposed Rule will be beneficial to ROW recipients by adding adult dental services and allowing flexibilities in delivery of waiver services.

FISCAL AND ECONOMIC IMPACT STATEMENT
WORKSHEET

I. A. COSTS OR SAVINGS TO STATE AGENCIES RESULTING FROM THE ACTION PROPOSED

1. What is the anticipated increase (decrease) in costs to implement the proposed action?

COSTS	FY 22	FY 23	FY 24
Personal Services			
Operating Expenses	$0	$0	$0
Professional Services			
Other Charges	$9,072	$1,502,146	$1,547,211
Equipment			
Major Repairs & Constr.			
TOTAL	**$9,072**	**$1,502,146**	**$1,547,211**
POSITIONS (#)			

2. Provide a narrative explanation of the costs or savings shown in "A. 1.", including the increase or reduction in workload or additional paperwork (number of new forms, additional documentation, etc.) anticipated as a result of the implementation of the proposed action. Describe all data, assumptions, and methods used in calculating these costs.

   The expenses reflected above are the estimated increases in expenditures in the Medicaid program. In FY 21-22, $12,096 is included for the state's administrative expense for promulgation of this proposed rule and the final rule.

3. Sources of funding for implementing the proposed rule or rule change.

SOURCE	FY 22	FY 23	FY 24
State General Fund	$4,536	$426,309	$468,210
Agency Self-Generated			
Dedicated	$0	$26,339	$35,098
Federal Funds	$4,536	$1,013,498	$1,043,903
Other (Specify)			
TOTAL	**$9,072**	**$1,502,146**	**$1,547,211**

4. Does your agency currently have sufficient funds to implement the proposed action? If not, how and when do you anticipate obtaining such funds?

   Yes, sufficient funds are available to implement this rule..

B. COST OR SAVINGS TO LOCAL GOVERNMENTAL UNITS RESULTING FROM THE ACTION PROPOSED.

1. Provide an estimate of the anticipated impact of the proposed action on local governmental units, including adjustments in workload and paperwork requirements. Describe all data, assumptions and methods used in calculating this impact.

   This proposed rule has no known impact on local governmental units.

2. Indicate the sources of funding of the local governmental unit, which will be affected by these costs or savings.

   There is no known impact on the sources of local governmental unit funding.

FISCAL AND ECONOMIC IMPACT STATEMENT
WORKSHEET

II. EFFECT ON REVENUE COLLECTIONS OF STATE AND LOCAL GOVERNMENTAL UNITS

A. What increase (decrease) in revenues can be anticipated from the proposed action?

REVENUE INCREASE/DECREASE	FY 22	FY 23	FY 24
State General Fund			
Agency Self-Generated			
Dedicated Funds	$0	$26,339	$35,098
Federal Funds	$4,536	$1,013,498	$1,043,903
Local Funds			
TOTAL	**$4,536**	**$1,502,146**	**$1,547,211**

*Specify the particular fund being impacted.

B. Provide a narrative explanation of each increase or decrease in revenues shown in "A." Describe all data, assumptions, and methods used in calculating these increases or decreases.

The amounts reflected above are the estimated increases in statutory dedicated revenue collections and federal revenue collections. In FY 21-22, $4,536 will be collected for the federal share of the administrative expense for promulgation of this proposed rule and the final rule.

FISCAL AND ECONOMIC IMPACT STATEMENT
WORKSHEET

III. COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS, SMALL BUSINESSES, OR NONGOVERNMENTAL GROUPS

A. What persons, small businesses, or non-governmental groups would be directly affected by the proposed action? For each, provide an estimate and a narrative description of any effect on costs, including workload adjustments and additional paperwork (number of new forms, additional documentation, etc.), they may have to incur as a result of the proposed action.

This proposed rule, in compliance with Act 450 of the 2021 Regular Session of the Louisiana Legislature, amends the provisions governing the Residential Options Waiver (ROW) in order to add adult dental services as a covered service. In addition, it also proposes to add waiver flexibilities in the delivery of ROW services including family as paid caregiver and shared services. This proposed rule will benefit ROW beneficiaries by covering adult dental services and allowing flexibility in the delivery of services.

B. Also provide an estimate and a narrative description of any impact on receipts and/or income resulting from this rule or rule change to these groups.

Providers will benefit from implementation of this proposed rule as it is anticipated that it will increase payments for services by approximately $1,502,146 for FY 22-23 and $1,547,211 for FY 23-24.

IV. EFFECTS ON COMPETITION AND EMPLOYMENT

Identify and provide estimates of the impact of the proposed action on competition and employment in the public and private sectors. Include a summary of any data, assumptions and methods used in making these estimates.

This rule has no known effect on competition and employment.