Subpart 7. Community Choices Waiver

Chapter 81. General Provisions

§8101. Introduction

A. The target population for the community choices waiver includes individuals who:

1. are 65 years of age or older; or

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

3. meet nursing facility level of care requirements.

B. Services are provided under the provisions of the approved waiver agreement between the Centers for Medicare and Medicaid Services (CMS) and the Louisiana Medicaid Program.

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

1. an individual requestor/applicant;

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

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

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

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

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

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

2. The functions of a responsible representative are to:

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

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

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

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

b. long-term personal care services;

c. the Community Choices Waiver; and

d. the Adult Day Health Care Waiver.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3517 (December 2011), amended LR 40:791 (April 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1896 (October 2018), repromulgated LR 44:2005 (November 2018).

§8103. Request for Services Registry

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

B. Individuals who desire their name to be placed on the community choices waiver registry shall be screened to determine whether they meet:

1. nursing facility level or care; and

2. are members of the target population as identified in the federally-approved waiver document.

C. Only individuals who pass the screen required in §8103.B.1-2 shall be added to the registry.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3517 (December 2011), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1896 (October 2018).

§8105. Programmatic Allocation of Waiver Opportunities

A. When funding is available for a new Community Choices Waiver opportunity or an existing opportunity is vacated, the department shall send a written notice to an individual on the registry indicating that a waiver opportunity is available. If the individual accepts the opportunity, that individual shall be evaluated for a possible Community Choices Waiver opportunity assignment.

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

1. individuals with substantiated cases of abuse or neglect referred by protective services who, without community choices waiver services, would require institutional placement to prevent further abuse or neglect;

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

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

4. individuals admitted to or residing in a nursing facility who have Medicaid as the sole payer source for the nursing facility stay;

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

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

b. long-term—personal care services (LT-PCS); and/or

c. any other 1915(c) waiver; and

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

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

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

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

1. To be considered for an expedited waiver opportunity, the individual must, at the time of the request for the expedited opportunity, be approved for the maximum amount of services allowable under the long –term personal care services and require institutional placement, unless offered an expedited waiver opportunity.

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

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

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

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3517 (December 2011), amended LR 39:319 (February 2013), LR 39:1778 (July 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1896 (October 2018), LR 45:756 (June 2019).

§8302. Long-Term Personal Care Services

A. Community choices waiver participants cannot also receive long-term personal care services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:320 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1897 (October 2018).

§8305. Environmental Accessibility Adaptations

A. Environmental accessibility adaptations are necessary physical adaptations that will be made to the home to reasonably assure the health and welfare of the participant, or enable the participant to function with greater independence in the home.

1. There must be an identified need for environmental accessibility adaptations as indicated by:

a. the interRAI assessment; or

b. supporting documentation of the need.

2. A credentialed environmental accessibility adaptation assessor must complete a written report that includes:

a. verification of the need for the adaptation(s);

b. draft job specifications; and

c. cost estimates for completion of the environmental accessibility adaptation(s).

3. The work must be completed by an enrolled, licensed contractor.

4. Environmental accessibility adaptation(s) shall meet all job specifications as outlined in the written report before payment is made to the contractor that performed the environmental accessibility adaptation(s).

a. If final inspection, either by OAAS staff or the assessor, reveals that the adaptation(s) is substandard, the costs of correcting the work will be the responsibility of the party in error.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3519 (December 2011), amended LR 39:320 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1897 (October 2018).

§8307. Personal Assistance Services

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

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

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

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

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

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

6. extension of therapy services, defined as follows:

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

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

B. PAS is provided in the participant's home or in another location outside of the home if the provision of these services allows the participant to participate in normal life activities pertaining to the ADLs and IADLs cited in the POC. IADLs may not be performed in the participant's home when the participant is absent from the home unless it is approved by OAAS or its designee on a case-by-case basis. There shall be no duplication of services. PAS may not be provided while the participant is admitted to or attending a program which provides in-home assistance with ADLs or IADLs or while attending or admitted to a program or setting where such assistance is provided.

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

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

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

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

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

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

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

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

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

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

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

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

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

H. Every PAS provider shall ensure timely completion of the emergency plan for each waiver participant they serve.

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

1. the participant's spouse;

2. the participant's curator;

3. the participant's tutor;

4. the participant's legal guardian;

5. the participant's responsible representative; or

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

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

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

K. It is permissible for the PAS allotment to be used flexibly within a prior authorized week in accordance with the participant's preferences and personal schedule and with proper documentation.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3519 (December 2011), amended LR 39:320 (February 2013), LR 39:1778 (July 2013), LR 40:791 (April 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1898 (October 2018), LR 47:885 (July 2021), LR 49:486 (March 2023).

§8309. Transition Services

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

individual is directly responsible for his/her own living expenses.

B. Allowable expenses are those necessary to enable the individual to establish a basic household (excluding expenses for room and board) including, but not limited to:

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

2. specific set up fees or deposits;

3. activities to assess need, arrange for and procure needed resources;

4. essential furnishings to establish basic living arrangements; and

5. health and welfare assurances.

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

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

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

F. Funds are available up to the lifetime maximum amount identified in the federally-approved waiver document.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3520 (December 2011), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1898 (October 2018).

§8313. Caregiver Temporary Support Services

A. Caregiver temporary support services are furnished on a short-term basis because of the absence or need for relief of caregivers during the time they are normally providing unpaid care for the participant.

B. Federal financial participation is not claimed for the cost of room and board except when provided as part of caregiver temporary support services furnished in a facility approved by the state that is not a private residence.

C. The intent of caregiver temporary support services is to provide relief to unpaid caregivers to maintain the informal support system.

D. Caregiver temporary support services are provided in the following locations:

1. the participant's home or place of residence;

2. nursing facilities;

3. assisted living facilities;

4. respite centers; or

5. adult day health care centers.

E. Caregiver temporary support services provided by nursing facilities, assisted living facilities and respite centers must include an overnight stay.

F. When Caregiver temporary support service is provided by an ADHC center, services may be provided no more than 10 hours per day.

G. Caregiver temporary services may be utilized no more than 30 calendar days or 29 overnight stays per plan of care year for no more than 14 consecutive calendar days or 13 consecutive overnight stays. The service limit may be increased based on documented need and prior approval by OAAS.

H. Caregiver temporary support may not be delivered at the same time as adult day health care or personal assistance services.

I. Caregiver temporary support may be provided for the relief of the principal caregiver for participants who receive monitored in-home caregiving (MIHC) services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3521 (December 2011), amended LR 39:321 (February 2013), LR 40:792 (April 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1898 (October 2018).

§8323. Skilled Maintenance Therapy

A. Skilled maintenance therapy is therapy services that may be received by participants in the home or rehabilitation center.

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

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

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

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

F. Skilled maintenance therapy services specifically include:

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

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

b. physical therapy treatments and interventions;

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

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

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

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

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

a. teaching of daily living skills;

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

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

d. provision of assistive technology services;

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

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

g. training regarding OT activities; and

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

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

a. identification of communicative or oropharyngeal disorders;

b. prevention of communicative or oropharyngeal disorders;

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

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

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

f. provision of assistive technology services;

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

h. training regarding SLT activities; and

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3522 (December 2011), amended LR 39:321 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1899 (October 2018), LR 47:885 (July 2021).

§8329. Monitored In-Home Caregiving Services

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

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

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

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

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

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

5. supervision or assistance while escorting/ accompanying the individual outside of the home to perform services indicated in the plan of care and to provide the same level of supervision or assistance as would be rendered in the home; and

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

C. Unless the individual is also the spouse of the participant, the following individuals are prohibited from being paid as a monitored in-home caregiving principal caregiver:

1. the participant's curator;

2. the participant's tutor;

3. the participant's legal guardian;

4. the participant's responsible representative; or

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

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

1. personal assistance services;

2. adult day health care services; or

3. home delivered meal services.

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 40:792 (April 2014), amended LR 41:2642 (December 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1900 (October 2018).

Chapter 86. Organized Health Care Delivery System

§8601. General Provisions

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

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

C. The OHCDS must attest that all applicable provider qualifications are met.

D. Prior to enrollment, an OHCDS must show the ability to provide all of the following community choices services:

1. personal assistance services (PAS);
2. home delivered meals;
3. skilled maintenance therapy;
4. nursing;
5. caregiver temporary support services;
6. assistive devices and medical supplies;

7. environmental accessibility adaptations (EAA); and

8. adult day health care (only if there is a licensed ADHC provider in the service area).

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 40:792 (April 2014), amended LR 41:2643 (December 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1901 (October 2018).

Chapter 87. Plan of Care

§8701. Plan of Care

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

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

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

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

2. individual cost of each waiver service; and

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3524 (December 2011), amended LR 39:321 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1901 (October 2018).

Chapter 89. Admission and Discharge Criteria

§8901. Admission Criteria

A. Admission to the community choices waiver program shall be determined in accordance with the following criteria:

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

2. initial and continued Medicaid eligibility;

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

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

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

B. Failure of the individual to cooperate in the eligibility determination, plan of care development process or to meet any of the criteria above shall result in denial of admission to the Community Choices Waiver.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3524 (December 2011), amended LR 39:322 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1901 (October 2018).

§8903. Admission Denial or Discharge Criteria

A. Admission shall be denied or the participant shall be discharged from the community choices waiver program if any of the following conditions are determined.

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

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

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

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

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

EXCEPTION: An exception may be granted by OAAS to delay discharge if interruption is due to an acute care hospital, rehabilitation hospital, or nursing facility admission.

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

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

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

9. It is not cost effective or appropriate to serve the individual in the Community Choices Waiver.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3524 (December 2011), amended LR 39:322 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1901 (October 2018).

Chapter 93. Provider Responsibilities

§9301. General Provisions

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

B. The provider shall not request payment unless the participant for whom payment is requested is receiving services in accordance with the community choices waiver program provisions and the services have been prior authorized and actually provided.

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

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

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

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

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

1. harassment;

2. intimidation; or

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3524 (December 2011), amended LR 39:322 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1901 (October 2018).

Chapter 95. Reimbursement

§9501. Reimbursement and Rate Requirements

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

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

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

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

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

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

4. adult day health care services;

5. housing transition or crisis intervention services; and

6. housing stabilization services.

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

1. environmental accessibility adaptations;

2. environmental accessibility adaption assessment and inspections;

3. assistive devices and medical supplies;

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

5. transition services (not to exceed the maximum lifetime limit set by OAAS);

6. monitored in-home caregiving (MIHC) assessment;

7. certain nursing, and skilled maintenance therapy procedures; and

8. assistive technology.

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

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

a. assisted living providers;

b. nursing facility; or

c. respite center; and

2. monitored in-home caregiving services.

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

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

1. support coordination;

2. transition intensive support coordination; and

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

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

1. certain nursing and skilled maintenance therapy procedures; and

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

F. Reimbursement shall not be made for community choices waiver services provided prior to the department’s approval of the POC and release of prior authorization for the services.

G. The minimum hourly rate paid to direct support professionals shall be at least the current federal or state minimum hourly rate.

H. The state has the authority to set and change provider rates and/or provide lump sum payments to providers based upon funds allocated by the legislature.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3525 (December 2011), amended LR 39:322 (February 2013), LR 39:508, 508 (March 2013), repromulgated LR 39:1048 (April 2013), amended LR 39:1779 (July 2013), LR 40:793 (April 2014), LR 42:897 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1902 (October 2018), LR 47:886 (July 2021), LR 49:487 (March 2023).