Subpart 9. Children's Choice

Chapter 111. General Provisions

§11101. Introduction

A. The children's choice (CC) waiver is a home and community-based services (HCBS) program that offers supplemental support to children with developmental disabilities who currently live at home with their families, or who will leave an institution to return home.

B. The children's choice waiver is an option offered to children on the developmental disabilities request for Services Registry (DDRFSR) or as identified in §11105 or §11107. Families may choose to accept a children's choice waiver offer or remain on the DDRFSR.

C. Children's choice waiver participants are eligible for all medically necessary Medicaid services in addition to children's choice waiver services.

D. The number of participants in the children's choice waiver is contingent upon available funding.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 26:2793 (December 2000), repromulgated for LAC, LR 28:1983 (September 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 35:1891 (September 2009), LR 39:2497 (September 2013).

§11103. Participant Qualifications and Admissions Criteria

A. The children's choice waiver is available to children who:

1. are from birth through age 18;

2. have a developmental disability as specified in R.S. 28:451.2;

3. are on the DDRFSR unless otherwise specified in §11105 and §11107;

4. meet all of the financial and non-financial Medicaid eligibility criteria for a home and community-based services (HCBS) waiver;

5. meet the requirements for an intermediate care facility for persons with developmental disabilities (ICF/DD) level of care, which requires active treatment of a developmental disability under the supervision of a qualified developmental disability professional;

6. meet the assurance requirements that the health and welfare of the individual can be maintained in the community with the provision of children's choice services;

7. have justification, as documented in the approved plan of care, that the children's choice services are appropriate, cost effective and represent the least restrictive environment for the individual;

8. are residents of Louisiana; and

9. are citizens of the United States or a qualified alien.

B. The plan of care must be sufficient to assure the health and welfare of the waiver applicant/participant in order to be approved for waiver participation or continued participation.

C. Children who reach their nineteenth birthday while participating in the children's choice waiver will transfer into an appropriate waiver for adults as long as they remain eligible for waiver 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 for Citizens with Developmental Disabilities, LR 35:1892 (September 2009), amended LR 39:2498 (September 2013).

§11104. Admission Denial or Discharge Criteria

A. Individuals shall be denied admission to or discharged from the children's choice waiver if one of the following criteria is met:

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

2. the individual does not meet the requirements for ICF/DD level of care;

3. the individual is incarcerated or placed under the jurisdiction of penal authorities, courts or state juvenile authorities;

4. the individual resides in another state or has a change of residence to another state;

5. the participant is admitted to an ICF/DD or nursing facility with the intent to stay and not to return to waiver services:

a. The waiver participant may return to waiver services when documentation is received from the treating physician that the admission is temporary and shall not exceed 90 days.

b. The participant will be discharged from the waiver on the ninety-first day if the participant is still in the ICF/DD or nursing facility.

6. the health and welfare of the individual cannot be assured through the provision of children's choice services within the individual's approved plan of care;

7. the individual fails to cooperate in the eligibility determination/re-determination process and in the development or implementation of the approved plan of care;

8. continuity of services is interrupted as a result of the participant not receiving a children's choice service during a period of 30 or more consecutive days:

a. This does not include interruptions in children's choice services because of hospitalization, institutionalization (such as ICFs/DD or nursing facilities), or non-routine lapses in services where the family agrees to provide all needed or paid natural supports.

b. There must be documentation from the treating physician that this interruption will not exceed 90 days.

c. During this 90-day period, the Office for Citizens with Developmental Disabilities (OCDD) will not authorize payment for children's choice services.

B. Children who reach their nineteenth birthday while participating in the children's choice waiver will transfer into an appropriate waiver for adults as long as they remain eligible for waiver 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 for Citizens with Developmental Disabilities, LR 39:2498 (September 2013).

§11105. Money Follows the Person Rebalancing Demonstration

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

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

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

1. Children with a developmental disability must:

a. be from birth through 18 years of age;

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

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

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

C. Children who participate in the demonstration are not required to have a protected request date on the DDRFSR. Children who are under the age of three years old and are not on the DDRFSR will be added to the DDRFSR at the age of three, or older, with a protected date that is the date of their approval to participate.

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

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

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

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

§11107. Allocation of Waiver Opportunities

A. The order of entry in the children's choice waiver is first come, first served from a statewide list arranged by date of application for the developmental disabilities request for services registry for the new opportunities waiver (NOW). Families shall be given a choice of accepting an opportunity in the children's choice waiver or remaining on the DDRFSR for the NOW.

1. The only exceptions to the first come, first served allocation of waiver opportunities shall be for the:

a. money follows the person rebalancing demonstration waiver opportunities which are allocated to demonstration participants only; and

b. waiver opportunities which are allocated to children who have been determined to need more services than what is currently available through state funded family support services.

c. Reserved.

B. An additional 20 children's choice waiver opportunities shall be created for the Money Follows the Person Rebalancing Demonstration Program and must only be filled by a demonstration participant. No alternate may utilize an MFP rebalancing demonstration opportunity.

1. The MFP rebalancing demonstration will stop allocation of opportunities on September 30, 2016.

a. In the event that an MFP rebalancing demonstration opportunity is vacated or closed before September 30, 2016, the opportunity will be returned to the MFP rebalancing demonstration pool and an offer will be made based upon the approved program guidelines.

b. In the event that an MFP rebalancing demonstration opportunity is vacated or closed after September 30, 2016, the opportunity will cease to exist.

C. Four hundred twenty-five opportunities shall be designated for qualifying children with developmental disabilities that have been identified by the local governing entity (LGE) as needing more family support services than what is currently available through state funded family support services

1. To qualify for these waiver opportunities, children must:

a. be under 18 years of age;

b. be designated by the LGE as meeting priority level 1 or 2 criteria;

c. be Medicaid-eligible;

d. be eligible for state developmental disability services; and

e. meet the ICF/DD level of care.

2. Each LGE shall be responsible for the prioritization of these opportunities. Priority levels shall be defined according to the following criteria.

a. Priority Level 1. Without the requested supports, there is an immediate or potential threat of out-of-home placement or homelessness due to:

i. the individual's medical care needs;

ii. documented abuse or neglect of the individual;

iii. the individual's intense or frequent challenging behavioral needs;

iv. death or inability of the caregiver to continue care due to his/her own age or health; or

v. the possibility that the individual may experience a health crisis leading to death, hospitalization or placement in a nursing facility.

b. Priority Level 2. Supports are needed to prevent the individual's health from deteriorating or the individual from losing any of his/her independence or productivity.

3. Children who qualify for one of these waiver opportunities are not required to have a protected request date on the developmental disabilities request for services registry.

4. Each LGE shall have a specific number of these opportunities designated to them for allocation to waiver participants.

5. In the event one of these opportunities is vacated, the opportunity shall be returned to the allocated pool for that particular LGE for another opportunity to be offered.

6. Once all of these opportunities are filled, supports and services, based on the priority determination system, will be identified and addressed through other resources currently available for individuals with developmental disabilities.

D. The Office for Citizens with Developmental Disabilities (OCDD) has the responsibility to monitor the utilization of children's choice waiver opportunities. At the discretion of the OCDD, specifically allocated waiver opportunities may be reallocated to better meet the needs of individuals with developmental disabilities.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 35:1892 (September 2009), amended LR 40:539, 540 (March 2014), LR 41:125 (January 2015).

Chapter 113. Service

§11301. Service Cap

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

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

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

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

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§11303. Service Definitions

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

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

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

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

a. environmental accessibility adaptations;

b. family training;

c. specialized medical equipment and supplies; or

d. support coordination.

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

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

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

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

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

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

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

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

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

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

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

1. Such adaptations to the home may include:

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

b. widening of doorways;

c. modification of bathroom facilities; or

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

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

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

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

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

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

7. Excluded are those adaptations or improvements to the home or vehicle which are of general utility, and are not

of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning, a fence, etc.

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

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

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

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

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

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

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

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

1. Family support includes:

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

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

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

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

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

G. Specialized Medical Equipment and Supplies

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

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

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

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

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

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

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

a. appliances;

b. personal computers and software;

c. daily hygiene products;

d. rent subsidy;

e. food;

f. bed linens;

g. exercise equipment;

h. taxi fares, bus passes, etc;

i. pagers and telephones; and

j. home security systems.

H. Aquatic Therapy

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

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

I. Art Therapy

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

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

J. Music Therapy

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

K. Sensory Integration

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

L. Hippotherapy/Therapeutic Horseback Riding

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

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

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

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

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

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

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

M. Housing Stabilization Transition Services

1. Housing stabilization transition services enable participants who are transitioning into a permanent supportive housing unit, including those transitioning from institutions, to secure their own housing. The service is provided while the participant is in an institution and preparing to exit the institution using the waiver.

2. Housing stabilization transition services include the following components:

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

i. access to housing;

ii. meeting the terms of a lease;

iii. eviction prevention;

iv. budgeting for housing/living expenses;

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

vi. home management;

vii. establishing credit; and

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

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

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

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

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

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

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

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

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

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

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

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

N. Housing Stabilization Services

1. Housing stabilization services enable waiver participants to maintain their own housing as set forth in the participant's approved plan of care. Services must be provided in the home or a community setting.

2. Housing stabilization services include the following components:

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

i. access to housing;

ii. meeting the terms of a lease;

iii. eviction prevention;

iv. budgeting for housing/living expenses;

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

vi. home management;

vii. establishing credit; and

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

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

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

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

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

g. providing supports to retain housing or locate and secure housing to continue community-based supports if the participant's housing is placed at risk (e.g., eviction, loss of roommate or income); this includes locating new housing, sources of income, etc.

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

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

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

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

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Chapter 115. Provider Participation Requirements

Subchapter A. Provider

Subchapter B. Provider Requirements

§11521. General Requirements for Medicaid Enrollment

A. In order to participate in the Medicaid Program, a provider must meet all of the following requirements.

1. The provider must meet all the requirements for licensure as established by state laws and rules promulgated by the Department of Health and Hospitals (DHH) or have a current, valid license or certification from the appropriate governing board for that profession.

2. The provider must agree to comply with all the terms and conditions for Medicaid enrollment as contained in:

a. the provider enrollment packet;

b. the Medical Assistance Program Integrity Law (MAPIL), R.S. 46:437.1 - 440.3;

c. the provider agreement;

d. the standards for participation contained in the Children's Choice and Case Management Services provider manuals; and

e. all other applicable federal and state laws, regulations and policies.

3. All services must be appropriately documented in the provider's records.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 27: 310 (March 2001), repromulgated for LAC, LR 28:1984 (September 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2501 (September 2013).

§11523. Enrollment

A. Both support coordination and direct services providers must comply with the requirements of this §11523 in order to participate as Children Choice providers. Agencies will not be added to the Freedom of Choice (FOC) list of available providers maintained by OCDD until they have received a Medicaid provider number.

B. Providers shall attend all mandated meetings and training sessions as directed by OCDD as a condition of enrollment and continued participation as waiver providers. Attendance at a provider enrollment orientation shall be required prior to enrollment as a Medicaid provider of services. The frequency of the provider enrollment orientations shall be determined by the DHH Health Standards Section.

C. A separate provider enrollment packet must be completed for each site in each DHH administrative region where the agency will provide services.

D. Participant case records and billing records shall be housed at the site in the DHH administrative region where the participant resides.

E. Providers may not refuse to serve any waiver participant that chooses their agency to provide services.

F. Providers shall have available computer equipment and software necessary to participate in prior authorization and data collection as described in the Children's Choice Provider Manual.

G. Providers shall participate in initial training for prior authorization and data collection. This initial training and any DHH scheduled subsequent training addressing program changes is to be provided at no cost to the agency. Repeat training must be paid for by the requesting agency.

H. Providers shall develop a Quality Improvement Plan which must be submitted for approval within 60 days after the DHH training. Self-assessments are due six months after approval of the plan and yearly thereafter.

I. The agency must not have been terminated or actively sanctioned by Medicaid, Medicare or other health-related programs in Louisiana or any other state.

J. The agency must not have an outstanding Medicaid program audit exception or other unresolved financial liability owed to the state.

K. Providers shall be certified for a period of one year. Re-certification must be completed no less than 60 days prior to the expiration of the certification period.

L. Waiver services are to be provided only to persons who are waiver participants, and strictly in accordance with the provisions of the approved plan of care.

M. Changes in the following areas are to be reported to both OCDD and the Provider Enrollment Section in writing at least 10 days prior to any change:

1. ownership;

2. physical location;

3. mailing address;

4. telephone number; and

5. account information affecting electronic funds transfer.

N. The provider must complete a new provider enrollment packet when a change in ownership of 5 percent to 50 percent of the controlling interest occurs, but may continue serving participants. When 51 percent or more of the controlling interest is transferred, a complete re-certification process must occur and the agency shall not continue serving participants until the re-certification process is complete.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 27:310 (March 2001), repromulgated for LAC by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1984 (September 2002), amended LR 28:2533 (December 2002), repromulgated LR 29:38 (January 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2501 (September 2013).

§11525. Case Management Providers

A. Case management providers must also comply with Paragraphs 1 and 2 of this Subsection A in order to participate as children choice providers.

1. Providers of case management services for the Children's Choice Program must have a contract with DHH to provide services to waiver participants.

2. Case management agencies must meet all requirements of their contract in addition to the requirements contained in the Children's Choice and Case Management Services Provider Manuals.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 27: 310 (March 2001), repromulgated for LAC, LR 28:1985 (September 2002).

§11527. Direct Service Providers

A. Direct service providers, except those listed in §11529, must also comply with §11527 in order to participate as children's choice providers.

1. The provider must be licensed by the DHH as a home and community-based services provider and meet the module specific requirements for the services being provided.

2. Direct service providers must provide, at a minimum, family support and crisis support services.

3. The following services may either be provided directly by the direct service provider or by written agreement (subcontract) with other agents. The actual provider of the service, whether it is the direct service provider or a subcontracted agent, shall meet the following licensure or other qualifications

a. Center-based respite must be provided by a facility licensed by DHH and meet all module specific requirements for the service.

b. Family training must be provided at approved events.

c. Environmental adaptations must be provided by an individual/agency deemed capable to perform the service by the participant's family and the direct service provider agency. When required by state law, the person performing the service must meet applicable requirements for a professional license. When building code standards are applicable, modifications to the home shall meet such standards.

d. Specialized Medical Equipment and Supplies agencies who are vendors of technological equipment and supplies must be enrolled in the Medicaid Program as a durable medical equipment provider and must meet all applicable vendor standards and requirements for manufacturing, design and installation of technological equipment and supplies.

e. All services must be performed and completed during the current approved plan of care year. Services that are not completed by the end of the current approved plan of care year will be voided and deemed as non-billable. Services cannot carry over into the next plan of care year.

4. Providers shall maintain a 24-hour toll-free telephone number manned by a person and shall provide a written plan to the participants, families and support coordinators that explains how workers can be contacted and the expected response time.

5. Providers shall develop and provide brochures to interested parties that document the agency's experience, toll-free telephone number, OCDD information, and other pertinent information. All brochures are subject to OCDD approval prior to distribution.

6. Agencies must provide services consistent with the personal outcomes identified by the child and his/her family.

7. All personnel who are at a supervisory level must have a minimum of one year verifiable work experience in planning and providing direct services to people with mental retardation or other developmental disabilities.

8. The agency shall document that its employees and the employees of subcontractors do not have a criminal record as defined in 42 CFR 441.404(b). Providers of community supported living arrangement services must:

a. not use individuals who have been convicted of child abuse, neglect, or mistreatment, or of a felony involving physical harm to an individual; and

b. take all reasonable steps to determine whether applications for employment by the provider have histories

indicating involvement in child or client abuse, neglect, or mistreatment, or a criminal record involving physical harm to an individual.

9. Direct service providers who contract with other agencies to provide waiver services shall maintain copies of such contracts signed by both agencies. Such contracts must state that the subcontractor may not refuse to serve any waiver participant referred to them by the enrolled direct service provider agency.

10. Direct service providers and subcontractors shall maintain written internal policy and procedure manuals that comply with the requirements contained in the children's choice provider manual.

11. Enrollment of direct service providers is contingent on the submission of a complete application packet.

12. Service delivery shall be documented with progress notes on participant status, supports provided that address personal outcomes, participant responses, etc. Progress notes shall be dated and signed in ink. Whiteout is not to be used in making corrections.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 27: 310 (March 2001), repromulgated for LAC, LR 28:1985 (September 2002), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1872 (September 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2501 (September 2013), LR 41:127 (January 2015), repromulgated LR 41:538 (March 2015).

Chapter 117. Crisis Provisions

§11701. Participation in Children's Choice

A. Families must choose to either accept children's choice services or remain on the DDRFSR. This is an individual decision based on a family's current circumstances. In the event that a family chooses children's

choice for their child and later experiences a crisis that increases the need for paid supports to a level that cannot be accommodated within the service cap specified in §11301.A on waiver expenditures, they may request consideration for a crisis designation. A crisis is defined as a catastrophic change in circumstances rendering the natural and community support system unable to provide for the health and welfare of the child at the level of benefits offered under children's choice. The procedure in this Chapter has been developed to address these situations.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 27:1015 (July 2001), repromulgated for LAC, LR 28:1986 (September 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2502 (September 2013).

§11703. Crisis Designation Criteria

A. In order to be considered a crisis, one of the following circumstances must exist:

1. death of the caregiver with no other supports (i.e., other family) available; or

2. the caregiver is incapacitated with no other supports (i.e., other family) available; or

3. the child is committed to the custody of the Department of Health and Hospitals (DHH) by the court; or

4. other family crisis with no caregiver support available, such as abuse/neglect, or a second person in the household becomes disabled and must be cared for by same caregiver, causing inability of the natural caregiver to continue necessary supports to assure health and safety; or

5. the child's condition deteriorates to the point when the plan of care is inadequate.

B. Exhausting available funds through the use of therapies, environmental accessibility adaptations, and specialized medical equipment and supplies does not qualify as justification for crisis designation.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 27:1015 (July 2001), repromulgated for LAC, LR 28:1986 (September 2002), amended LR 29:704 (May 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2503 (September 2013), LR 41:128 (January 2015).

§11705. Crisis Extension Provisions

A. Additional services (crisis support) outside of the waiver cap amount shall be approved by the OCDD state office. Crisis designation is time limited, depending on the anticipated duration of the causative event. Each request for crisis designation may be approved for a maximum of three months or the annual plan of care date, not to exceed 12 months.

B. When the crisis designation is extended at the end of the initial duration (or at any time thereafter), the family may request the option of returning the child's name to the original application date on the DDRFSR when it is determined that the loss of the caregiver and lack of natural or community supports will be long term or permanent. This final determination will be made by OCDD. Eligibility and services through children's choice shall continue as long as the child meets eligibility criteria.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 27:1015 (July 2001), repromulgated for LAC, LR 28:1986 (September 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2503 (September 2013).

Chapter 119. Noncrisis Provisions

§11901. General Provisions

A. Restoring the participant to the DDRFSR under noncrisis provisions will allow that individual to be placed in the next available waiver opportunity (slot) that will provide the appropriate services, provided the participant is still eligible when a slot becomes available. The fact that the participant is being restored to the DDRFSR does not require that the department immediately offer him/her a waiver slot if all slots are filled or to make a slot available to this participant for which another participant is being evaluated, even though that other participant was originally placed on the DDRFSR on a later date. Waiver services will not be terminated as a result of a participant's name being restored to the registry.

B. If another developmental disabilities waiver would provide the participant with the services at issue, the department may place the participant in any waiver that would provide the appropriate services.

C. In the event that the waiver eligibility, other than for the developmental disabilities waiver, of a person who elected or whose legal representative elected that he/she receive services under the children's choice waiver is terminated based on inability to assure health and welfare of the waiver participant, the department will restore him/her to the DDRFSR for the developmental disabilities waiver in the date order of the original request.

D. If and when a new adult waiver is adopted, a children's choice participant aging out of that program will be evaluated for both the capped waiver and the developmental disabilities waiver, and transferred to the waiver which services are most appropriate for him/her at that time, with a right of appeal of the department's decision.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1465 (June 2002), repromulgated for LAC, LR 28:1986 (September 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2503 (September 2013), LR 41:128 (January 2015).

§11903. Good Cause

A. A person who has elected or whose legal representative has elected that they receive services under children's choice waiver shall be allowed to restore his or her name to the DDRFSR for the developmental disabilities waiver in original date order, when they meet all of the following criteria:

1. he/she would benefit from the services that are available in the developmental disabilities waiver, but are not actually available to him or her through his/her current waiver or through Medicaid State Plan services; and

2. he/she would qualify for those services under the standards utilized for approving and denying the services to the developmental disabilities waiver participants; and

3. there has been a change in circumstances since his or her enrollment in the children's choice waiver that causes these other services to be appropriate. The change does not have to be a change in the participant's medical condition, but can include loss of in-home assistance through a caretaker's decision to take on or increase employment, or to obtain education or training for employment. (Note: The temporary absence of a caretaker due to a vacation is not considered good cause.); and

4. the person's original request date for the developmental disabilities waiver has been passed on to the DDRFSR.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1465 (June 2002), repromulgated for LAC, LR 28:1986 (September 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2503 (September 2013).

§11905. Determination Responsibilities and Appeals

A. The LGE shall have the responsibility for making the determinations as to the matters set forth in this Chapter 119. Persons who have elected or whose legal representatives have elected that they receive services under the children's choice waiver have the right to appeal any determination of the department as to matters set forth in this Chapter 119, under the regulations and procedures applicable to Medicaid fair hearings.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1465 (June 2002), repromulgated for LAC, LR 28:1987 (September 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2504 (September 2013), LR 41:128 (January 2015).

Chapter 123. Self-Direction Initiative

§12301. Self-Direction Service Delivery Option

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

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

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

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

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

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

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

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

c. an administrative fee will be deducted from the participant's approved budget;

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

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

C. Termination of the Self-Direction Service Option. Termination of participation in the self-direction service delivery option requires a revision of the plan of care, the elimination of the fiscal agent and the selection of the Medicaid-enrolled waiver service provider(s) of choice.

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

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

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

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

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

d. over three payment cycles in a one year period, the participant or authorized representative:

i. places barriers to the payment of the salaries and related state and federal payroll taxes of direct support staff;

ii. fails to follow the approved budget;

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

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

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

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