NOTICE OF INTENT

Department of Health
Bureau of Health Services Financing
and
Office of Aging and Adult Services

Home and Community-Based Services Waivers
Adult Day Health Care Waiver
(LAC 50:XXI.Chapters 21-27)

The Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services propose to amend LAC 50:XXI.Chapters 21-27 under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services (OAAS) propose to amend the provisions governing the Adult Day Health Care (ADHC) Waiver in order to: 1) align these provisions with the waiver approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS); 2) ensure consistency across OAAS waivers and the standard language used in other OAAS administrative rules; 3) provide the option for participants to designate a responsible representative; 4) amend the criteria for priority offers to specify priority for individuals admitted to, or residing in, nursing facilities who

have Medicaid as the sole payer source; and 5) allow OAAS to grant exceptions to waiver discharges due to qualifying circumstances.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community-Based Services Waivers
Subpart 3. Adult Day Health Care Waiver

Chapter 21. General Provisions

§2101. Introduction

A. These standards for participation specify the requirements of the Adult Day Health Care (ADHC) Waiver Program. The program is funded as a waived service under the provisions of Title XIX of the Social Security Act and is administrated by the Department of Health ~~and Hospitals~~ (~~DHH~~LDH).

B. – C. ...

D. Each individual who requests ADHC 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 ADHC 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.

i. 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. 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 including:

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

b. long-term personal care services (LT-PCS);

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 Human Resources, Office of Family Security, LR 11:623 (June 1985), repromulgated LR 13:181 (March 1987),amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1149 (September 1997), repromulgated LR 30:2034 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2161 (October 2008), repromulgated LR 34:2565 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2494 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§2105. Request for Services Registry

[Formerly §2107]

A. The Department of Health ~~and Hospitals~~ is responsible for the Request for Services Registry, hereafter referred to as "the registry", for the ~~Adult Day Health Care~~ ADHC Waiver. An individual who wishes to have his or her name placed on the registry shall contact a toll free telephone number, which shall be maintained by LDH.

B. Individuals who desire their name to be placed on the ADHC waiver registry shall be screened to determine whether they ~~meet nursing facility level of care. Only individuals who pass this screen shall be added to the registry.~~:

1. meet nursing facility level of care; and

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

C. Only individuals who pass the screening in §2105.B shall be added to the registry.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and pursuant to 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 30:2035 (September 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services, LR 32:2256 (December 2006), LR 34:2161 (October 2008), repromulgated LR 34:2566 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2495 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§2107. Programmatic Allocation of Waiver Opportunities

A. When funding is appropriated for a new ADHC ~~W~~waiver opportunity or an existing opportunity is vacated, the ~~D~~department shall send a written notice to an individual on the registry indicating that a waiver opportunity is available. That individual shall be evaluated for a possible ADHC ~~W~~waiver opportunity assignment.

B. Adult day health care waiver opportunities shall be offered to individuals on the registry according to priority groups. The following groups shall have priority for ADHC waiver opportunities in the order listed:

1. individuals with substantiated cases of abuse or neglect ~~with Adult~~ referred by ~~P~~protective ~~S~~services ~~(APS) or Elderly Protective Services (EPS) and~~ who, ~~absent~~ without ADHC waiver services, would require institutional placement to prevent further abuse and neglect;

2. individuals who have been discharged after a hospitalization within the past 30 calendar days that involved a stay of at least one night;

3. individuals admitted to, or residing in, a nursing facility who have Medicaid as the sole payer source for the nursing facility stay ~~are approved for a stay of more than 90 days~~; and

B.4. – C. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2162 (October 2008), repromulgated LR 34:2566 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2624 (September 2011), LR 39:2495 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Chapter 23. Services

§2301. Covered Services

A. The following services are available to ~~recipients~~ participants in the ADHC ~~w~~Waiver. All services must be provided in accordance with the approved plan of care (POC). No services shall be provided until the POC has been approved.

1. Adult Day Health Care. ~~ADHC s~~Services furnished as specified in the ~~plan of care~~ POC at ~~the~~ a licensed ADHC center, in a non-institutional, community-based setting encompassing both health/medical and social services needed to ensure the optimal functioning of the participant. Services are furnished on a regularly scheduled basis, not to exceed 10 hours a day, 50 hours a week. ~~An adult day health care center shall,~~

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

a. ~~assistance with activities of daily living~~medical care management; and

b. ~~health and nutrition counseling~~transportation to and from medical and social activities (if the participant is accompanied by the ADHC center staff)~~;~~.

~~c. individualized, exercise program;~~

~~d. individualized, goal directed recreation program;~~

~~e. health education classes;~~

~~f. meals shall not constitute a "full nutritional regimen" (three meals per day) but shall include a minimum of two snacks and a nutritional lunch;~~

~~g. individualized health/nursing services;~~

~~i. monitoring vital signs appropriate to the diagnosis and medication regimen of each recipient no less frequently than monthly;~~

~~ii. administering medications and treatments in accordance with physicians' orders;~~

~~iii. monitoring self-administration of medications while the recipient is at the ADHC center;~~

~~NOTE: All nursing services shall be provided in accordance with acceptable professional practice standards.~~

~~h. transportation to and from the center at the beginning and end of the program day;~~

~~i. transportation to and from medical and social activities when the participant is accompanied by center staff; and~~

~~j. transportation between the participant's place of residence and the ADHC in accordance with licensing standards.~~c. – j. Repealed.

2. Support Coordination. These services assist participants in gaining access to necessary waiver and other state plan services, as well as needed medical, social, educational, housing, and other services, regardless of the funding source for these services. Support coordination agencies shall be required to perform the following core elements of support coordination services:

a. ...

b. assessment and reassessment;

c. ...

d. ~~linkage to direct services and other resources~~follow-up/monitoring;

e. ~~coordination of multiple services among multiple providers~~critical incident management; and

f. ~~monitoring/follow-up~~transition/discharge and closure~~;~~.

~~g. reassessment;~~

~~h. evaluation and re-evaluation of level of care and need for waiver services;~~

~~i. ongoing assessment and mitigation of health, behavioral and personal safety risk;~~

~~j. responding to participant crises;~~

~~k. critical incident management; and~~

~~l. transition/discharge and closure.~~g. – l. Repealed.

3. Transition Intensive Support Coordination. These services will assist participants currently residing in nursing facilities in gaining access to needed waiver and other state plan services, as well as needed medical, social, housing, educational and other services regardless of the funding source for these services. Support coordinators shall initiate and oversee the process for assessment and reassessment, as well as be responsible for ongoing monitoring of the provision of services included in the participants approved POC.~~This service is paid up to 180 days prior to transitioning from the nursing facility when adequate pre-transition support and activity are provided and documented. This service is available to~~

~~participants during transition from a nursing facility to the community.~~

a. This service is paid up to six months prior to transitioning from the nursing facility when adequate pre-transition supports and activities are provided and documented.

b. The scope of transition intensive support coordination shall not overlap with the scope of support coordination.

c. Support coordinators may assist participants to transition for up to six months while the participants still resides in the facility.

4. Transition Services. These services ~~that will assist an individual transition from a nursing facility to a living arrangement in a private residence where the individual is directly responsible for his/her own living expenses~~ are time limited, non-recurring set-up expenses available for individuals who have been offered and approved for an ~~adult day health care~~ ADHC 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 expenses. ~~Allowable expenses are those necessary to enable the individual to establish a basic household that does not constitute room and board, but include:~~

a. ~~security deposits that are required to obtain a lease on an apartment or house~~Allowable expense are those necessary to enable the individual to establish a basic household (excluding expenses for room and board) including, but not limited to:

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

ii. specific set up fees or deposits

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

iv. essential furnishings to establish basic living arrangements; and

v. health, safety, and welfare assurances.

b. ~~specific set up fees or deposits (telephone, electric gas, water and other such necessary housing set-up fees or deposits); and~~These services must be prior approved in the participant's plan of care.

c. ~~essential furnishings to establish basic living arrangements; and health and welfare assurances (pest control/eradication, fire extinguisher, smoke detector and first aid supplies/kit)~~These services do not include monthly rental, mortgage expenses, food, recurring monthly utilities charges and household appliances and/or items intended for purely diversional/recreational purposes.

d. These services may not be used to pay for furnishings or 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.

~~B. These services must be prior approved in the participant's plan of care.~~

~~C. These services do not include monthly rental, mortgage expenses, food, monthly utilities charges and household appliances and/or items intended for purely diversional/recreational purposes.~~

~~D. These services may not be used to pay for furnishings or 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. Funds are available one time per $1500 lifetime maximum for specific items as prior approved in the participant's POC.~~B. – E. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 11:623 (June 1985), amended LR 13:181 (March 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1149 (September 1997), amended LR 25:1100 (June 1999), repromulgated LR 30:2036 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2162 (October 2008), repromulgated LR 34:2566 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011), LR 39:2495 (September 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:

§2303. Individualized Service Plan

A. All participants shall have an ADHC ~~services shall~~individualized service plan (ISP) written in accordance with ADHC licensing standards (LAC 48:I.4281)~~:~~.

~~1. be provided according to the individualized service plan;~~

~~2. be a result of an interdisciplinary staffing in which the participant and direct care staff participate;~~

~~3. be written in terminology which all center personnel can understand;~~

~~4. list the identified problems and needs of the participant for which intervention is indicated as identified in assessments, progress notes and medical reports;~~

~~5. propose a reasonable, measurable short-term goal for each problem/need;~~

~~6. contain the necessary elements of the center's self administration of medication plan, if applicable;~~

~~7. use the strengths of the participant in developing approaches to problems;~~

~~8. specify the approaches to be used for each problem and that each approach is appropriate to effect positive change for that problem;~~

~~9. identify the staff member responsible for carrying out each approach;~~

~~10. project the resolution date or review date for each problem;~~

~~11. specify the frequency of each approach/service;~~

~~12. contain a sufficient explanation of why the participant would require 24-hour care were he/she not receiving ADHC services;~~

~~13. include the number of days and time of scheduled attendance each week;~~

~~14. include discharge as a goal; and~~

~~15. be kept in the participant's record used by direct care staff.~~1. – 15. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 11:623 (June 1985), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 13:181 (March 1987), LR 23:1150, 1156 and 1163 (September 1997), LR 28:2356 (November 2002), repromulgated LR 30:2036 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2162 (October 2008), repromulgated LR 34:2567 (December 2008), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§2305. Plan of Care

A. The applicant and support coordinator have the flexibility to construct a plan of care (POC) that serves the participant's health, safety and welfare needs. The service package provided under the POC shall include services covered under the ~~a~~Adult ~~d~~Day ~~h~~Health ~~c~~Care ~~w~~Waiver in addition to services covered under the Medicaid ~~s~~State ~~p~~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.

1. – B. ...

C. The POC 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 individual 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 39:2496 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Chapter 25. Admission and Discharge Criteria

§2501. Admission Criteria

A. Admission to the ADHC Waiver Program shall be determined in accordance with the following criteria:

1. ...

2. initial and continued Medicaid ~~financial~~ eligibility;

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

4. ...

5. reasonable assurance that the health, safety and welfare of the individual can be maintained in the community with the provision of ADHC waiver services.

B. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 11:626 (June 1985), amended LR 13:181 (March 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1153 (September 1997), repromulgated LR 30:2040 (September 2004), amended by the Department Of Hospitals, Office of Aging and Adult Services, LR 34:2163 (October 2008), repromulgated LR 34:2568 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011), LR 39:2496 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§2503. Admission Denial or Discharge Criteria

A. Admission shall be denied or the ~~recipient~~ participant shall be discharged from the ADHC Waiver Program if any of the following conditions are determined~~.~~:

1. The individual does not meet the ~~criteria for Medicaid financial eligibility~~target population criteria as specified in the federally approved waiver document.

2. The individual does not meet the criteria for ~~a nursing facility level of care~~Medicaid eligibility.

3. ~~The recipient resides in another state or has a change of residence to another state~~The individual does not meet the criteria for nursing facility level of care.

4. ~~Continuity of services is interrupted as a result of the recipient not receiving and/or refusing ADHC Waiver services (exclusive of support coordination services) for a period of 30 consecutive days~~The individual resides in another state or the participant has a change of residence to another state.

5. ~~The health and welfare of the individual cannot be assured through the provision of~~ Continuity of services is interrupted as a result of the participant not receiving and/or refusing ADHC waiver services (exclusive of support coordination services) for a period of 30 consecutive days.

a. Exceptions 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, safety and welfare of the individual ~~fails to cooperate in the eligibility determination process, POC development, or in the performance of the POC~~cannot be assured through the provision of ADHC waiver services.

7. ~~It is not cost effective to serve t~~The individual/participant ~~in the ADHC Waiver~~fails to cooperate in the eligibility determination process, POC development, or in the performance of the POC.

8. ~~The participant fails to attend the ADHC center for a minimum of 36 days per calendar quarter~~It is not cost effective or appropriate to serve the individual in the ADHC Waiver.

9. The ~~individual~~participant fails to ~~maintain a safe and legal home environment~~attend the ADHC center for a minimum of 36 days per calendar quarter.

10. The participant fails to maintain a safe and legal home environment.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2163

(October 2008), repromulgated LR 34:2568 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011), LR 39:2496 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Chapter 27. Provider Responsibilities

§2701. General Provisions

A. Each ~~adult day health care~~ADHC center shall~~ enter into a provider agreement with the department to provide services which may be reimbursed by the Medicaid Program, and shall agree to comply with the provisions of this Rule.~~:

1. be licensed by the Department of Health, Health Standards Section, in accordance with LAC 48:I.Chapter 42;

2. enroll as an ADHC Medicaid provider;

3. enter into a provider agreement with the department to provide services; and

4. agree to comply with the provisions of this Rule.

B. The provider ~~agrees to~~ shall not request payment unless the participant for whom payment is requested is receiving services in accordance with the ADHC Waiver program provisions and the services have been prior authorized and delivered.

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

1. – 2. ...

D. Providers must maintain adequate documentation ~~as specified by OAAS, or its designee,~~ 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. Adult day health care providers 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 the participant's informal support network, LDH staff, or support coordination staff.

F. Adult day health care providers shall have the capacity and resources to provide all aspects of the services

they are enrolled to provide in the specified licensed 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 Human Resources, Office of Family Security, LR 11:627 (June 1985), amended LR 13:181 (March 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1155 (September 1997), LR 24:457 (March 1998), repromulgated LR 30:2041 (September 2004), amended by the Department of Health and Hospitals, Office for Aging and Adult Services, LR 34:2164 (October 2008), repromulgated LR 34:2568 (December 2008),), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011), LR 39:2497 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§2703. Reporting Requirements

A. Support coordinators and direct service providers, including ADHC providers, are obligated to immediately report ~~within specified time lines,~~ any changes to the department that could affect the waiver participant's eligibility including, but

not limited to, those changes cited in the denial or discharge criteria listed in §2503.

B. Support coordinators and direct service providers, including ADHC providers, are responsible for documenting the occurrence of incidents or accidents that affect the health, safety and welfare of the ~~recipient~~ participant and completing an incident report. The incident report shall be submitted to the department or its designee with the specified requirements within specified time lines.

C. ...

D. ~~ADHC~~ Adult day health care providers shall provide the participant's approved individualized service plan to the support coordinator in a timely 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, Office of the Secretary, Office of Aging and Adult Services, LR 34:2164 (October 2008), repromulgated LR 34:2568 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2497 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§2705. Electronic Visit Verification

~~A. Effective for dates of service on or after November 1, 2015, Adult Day Health Care Waiver providers shall use the electronic visit verification (EVV) system designated by the department for automated scheduling, time and attendance tracking and billing for certain home and community-based services.~~

~~B. Reimbursement shall only be made to providers with documented use of the EVV system. The services that require use of the EVV system will be published in the ADHC Waiver provider manual.~~Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 43:74 (January 2017), repealed by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on

the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Interested persons may submit written comments to Jen Steele, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821–9030 or by email to MedicaidPolicy@la.gov. Ms. Steele is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Thursday, October 25, 2018 at 9:30 a.m. in Room

118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Rebekah E. Gee MD, MPH

Secretary