Subpart 13. Residential Options Waiver

Chapter 161. General Provisions

§16101. Introduction

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

B. The Residential Options Waiver services are provided with the goal of promoting independence through strengthening the beneficiary's capacity for self-care, self-sufficiency and community integration utilizing a wide array of services, supports and residential options. The ROW is person-centered incorporating the beneficiary's support needs and preferences, while supporting the dignity, quality of life, and security with the goal of integrating the participant into the community.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2441 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2154 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1764 (December 2019), LR 47:1507 (October 2021), LR 48:1558 (June 2022).

§16103. Program Description

A. The ROW is designed to utilize the principles of self-determination and to supplement the family and/or community supports that are available to maintain the individual in the community and are designed to allow an individual experience that mirrors the experiences of individuals without disabilities. These services are not to be restrictive, but liberating, by empowering individuals to experience life in the most fulfilling manner as defined by the individual while still assuring health and safety. In keeping with the principles of self-determination, ROW includes a self-direction option, which allows for greater flexibility in hiring, training and general service delivery issues. ROW services are meant to enhance, not replace existing informal networks.

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

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

2. offer an alternative to institutionalization and costly comprehensive services through the provision of an array of services and supports that promote community inclusion and independence by enhancing and not replacing existing informal networks; and

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

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

service provider agencies through the freedom of choice process.

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

D. All services must be prior authorized and delivered in accordance with the approved POC.

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

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

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

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

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

5. All Medicaid service options will be explored, including ICF/IID placement, based upon the assessed need.

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2441 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2154 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1764 (December 2019), LR 47:1507 (October 2021), LR 48:1559 (June 2022).

§16104. Settings for Home and Community Based Services

A. ROW beneficiaries are expected to be integrated in and have full access to the greater community while receiving services, to the same extent as individuals without disabilities. Providers shall meet the requirements of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) home and community-based setting requirements for home and community-based services (HCBS) waivers as delineated in LAC 50:XXI.901 or any superseding rule.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1764 (December 2019), amended LR 47:1508 (October 2021), LR 48:1559 (June 2022).

§16106. Money Follows the Person Rebalancing Demonstration

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

1. For the purposes of these provisions, a qualified institution is a nursing facility, hospital, or Medicaid enrolled intermediate care facility for individuals with intellectual disabilities (ICF/IID).

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

1. Individuals with a developmental disability must:

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

b. be Medicaid eligible, eligible for state developmental disability services, and meet an ICF/IID level of care.

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

C. Individuals in the demonstration are not required to have a protected date on the developmental disabilities request for services registry (RFSR).

D. All other ROW provisions apply to the Money Follows the Person Rebalancing Demonstration.

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2155 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1508 (October 2021), LR 48:1559 (June 2022).

§16107. Programmatic Allocation of Waiver Opportunities

A. The intellectual/developmental disabilities request for services registry, hereafter referred to as "the registry," shall be used to identify individuals with intellectual and/or developmental disabilities who are waiting for an OCDD waiver opportunity. Individuals who are found eligible for developmental disabilities services using standardized tools, and who request waiver services will be added to the registry. The request for services registry (RFSR) is arranged by urgency of need and date of application for developmentally disabled (DD) waiver services.

B. The ROW serves eligible individuals in the following populations and is based on the following priorities:

1. Priority 1. The one-time transition of persons eligible for developmental disability (DD) services in either OAAS Community Choices Waiver (CCW) or OAAS Adult Day Health Care (ADHC) Waiver to the ROW.

2. Priority 2. Individuals living at Pinecrest Supports and Services Center or in a publicly operated ICF/IID when it was transitioned to a private ICF/IID through a cooperative endeavor agreement (CEA facility), or their alternates. Alternates are defined as individuals living in a private ICF/IID who will give up the private ICF/IID bed to an individual living at Pinecrest or to an individual who was living in a publicly operated ICF/IID when it was transitioned to a private ICF/IID through a cooperative endeavor agreement. Individuals requesting to transition from Pinecrest are awarded a slot when one is requested and their health and safety can be assured in an OCDD waiver. This also applies to individuals who were residing in a state operated facility at the time the facility was privatized and became a CEA facility.

3. Priority 3. Individuals on the registry who have the highest level of need and the earliest registry date shall be notified in writing when a funded OCDD waiver opportunity is available and that he/she is next in line to be evaluated for a possible waiver assignment, and the ROW shall have justification based on a uniform needs-based assessment and a person-centered planning that the ROW is the OCDD waiver that will best meet the needs of the individual.

4. Priority 4. Individuals transitioning from ICF/IID facilities utilizing ROW conversion.

C. OCDD has the responsibility to monitor the utilization of ROW opportunities. At the discretion of OCDD, specifically allocated waiver opportunities may be reallocated to better meet the needs of citizens with developmental disabilities in the state of Louisiana.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2441 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2155 (October 2015), LR 42:62 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2530 (December 2017), LR 45:1764 (December 2019), LR 47:1508 (October 2021).

§16109. Admission Denial or Discharge Criteria

A. Admission to the ROW Program shall be denied if one of the following criteria is met.

1. The individual does not meet the requirements for an ICF/IID level of care.

2. The individual does not meet the requirements for an ICF/ID level of care.

3. The individual does not meet developmental disability system eligibility.

4. The individual is incarcerated or under the jurisdiction of penal authorities, courts or state juvenile authorities.

5. The individual resides in another state.

6. The health and welfare of the individual cannot be assured through the provision of ROW services.

7. The individual fails to cooperate in the eligibility determination process or in the development of the POC.

8. The individual does not have justification, based on a uniform needs-based assessment and a person-centered planning discussion that the ROW is the OCDD waiver that will meet the needs of the individual.

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

1. loss of Medicaid financial eligibility as determined by the Medicaid Program;

2. loss of eligibility for an ICF/IID level of care;

3. loss of developmental disability system eligibility;

4. incarceration or placement under the jurisdiction of penal authorities, courts, or state juvenile authorities;

5. change of residence to another state;

6. admission to an ICF/IID or nursing facility with the intent to stay and not to return to waiver services;

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

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

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

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2443 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2156 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1765 (December 2019), LR 47:1509 (October 2021), LR 48:1560 (June 2022).

Chapter 163. Covered Services

§16301. Assistive Technology and Specialized Medical Equipment and Supplies

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

1. This service also includes items that meet at least one of the following criteria:

a. items that are necessary for life support;

b. items that are necessary to address physical conditions, along with ancillary supplies;

c. address physical conditions;

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

e. equipment necessary to the proper functioning of such items.

2. This service also includes medically necessary durable and non-durable equipment not available under the Medicaid State Plan and repairs to such items and equipment necessary to increase/maintain the independence and well-being of the beneficiary.

a. All equipment, accessories and supplies must meet all applicable manufacture, design and installation requirements.

b. The services under the Residential Options Waiver are limited to additional services not otherwise covered under the Medicaid State Plan.

3. The services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

2. services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

3. coordination of necessary therapies, interventions or services with assistive technology devices;

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

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

6. all service contracts and warranties included in the purchase of the item by the manufacturer;

7. equipment or device repair and replacement of batteries and other items that contribute to ongoing maintenance of the equipment or device;

a. separate payment will be made for repairs after expiration of the warranty only when it is determined to be cost effective; and

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

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

1. Items reimbursed in the ROW may be in addition to any medical equipment and supplies furnished under the Medicaid State Plan.

D. All assistive technology items must meet applicable manufacture, design and installation requirements.

E. Service Exclusions

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

2. Any equipment, device, appliance or supply that is covered and has been approved under the Medicaid State Plan is excluded from coverage.

3. For adults over the age of 20 years, specialized chairs, whether mobile or travel are not covered.

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

1. be enrolled in the Medicaid Program;

2. provide documentation on manufacturer's letterhead that the agency listed on the Louisiana Medicaid Enrollment Form and Addendum (PE-50) is:

a. authorized to sell and install assistive technology, specialized medical equipment and supplies, or devices for assistance with activities of daily living; and

b. has training and experience with the application, use fitting and repair of the equipment or devices they propose to sell or repair; and

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2443 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2156 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1509 (October 2021), LR 48:1560 (June 2022)..

§16303. Community Living Supports

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

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

1. self-help skills;

2. socialization skills;

3. cognitive and communication skills; and

4. development of appropriate, positive behaviors.

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

D. Community living supports may be shared by up to three beneficiaries who may or may not live together, and

who have a common direct service provider agency. In order for CLS services to be shared, the following conditions must be met.

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

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

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

4. A shared rate must be billed.

5. The cost of transportation is built in to the community living services rate and must be provided when integral to community living services.

E. Service Exclusions

1. Community living supports staff are not allowed to sleep during billable hours of community living supports.

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

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

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

a. shared living;

b. host home; or

c. companion care.

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

a. day habitation;

b. prevocational services;

c. supported employment;

d. respite care services-out of home;

e. transportation-community access;

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

g. adult day health care.

F. Provider Qualifications. CLS providers must be licensed by the Department of Health as a home and community-based services provider and meet the module requirements for personal care attendant in LAC 48:I.Chapter 50.

1. Family members who provide CLS services must meet the same standards as providers who are unrelated to the beneficiary. Service hours shall be capped at 40 hours per week, Sunday to Saturday, for services delivered by family members living in the home.

2. Legally responsible individuals (such as a parent or spouse) and legal guardians may provide community living supports services for a beneficiary provided that the care is extraordinary in comparison to that of a beneficiary of the same age without a disability and the care is in the best interest of the beneficiary.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2443 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2157 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1765 (December 2019), LR 47:1510 (October 2021), LR 48:1561 (June 2022).

§16305. Companion Care

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

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

2. community integration and coordination of transportation services, including medical appointments.

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

C. Provider Responsibilities

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

a. types of support provided by the companion;

b. activities provided by the companion; and

c. a typical weekly schedule.

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

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

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

a. arranging the delivery of services and providing emergency services as needed;

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

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

d. providing 24-hour oversight, back-up staff, and companion supervision.

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

D. Responsibilities of the companion include:

1. providing assistance with activities of daily living (ADLs);

2. community integration;

3. providing transportation;

4. coordinating and assisting as needed with transportation to medical/therapy appointments;

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

6. maintaining documentation/records in accordance with state and provider requirements;

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

8. purchasing own personal items and food; and

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

E. Service Limits

1. The provider must provide relief staff for scheduled and unscheduled absences, available for up to 360 hours (15 days) per plan of care year. The companion care provider's rate includes funding for relief staff for scheduled and unscheduled absences.

F. Service Exclusions

1. Companion care is not available to individuals receiving the following services:

a. respite care service–out of home;

b. shared living;

c. community living supports;

d. host home; or

e. monitored in-home caregiving (MIHC).

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

3. Legally responsible individuals and legal guardians may provide companion care services for a relative who beneficiary provided that the care is extraordinary in comparison to that of a beneficiary of the same age without a disability and the care is in the best interest of the beneficiary.

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

5. Transportation is billed by the vocational provider.

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2444 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2158 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1765 (December 2019), LR 47:1511 (October 2021), LR 48:1561 (June 2022).

§16307. Day Habilitation Services

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

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

1. onsite day habilitation;

2. community life engagement; and

3. virtual day habilitation.

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

beneficiary's meaningful day including community activities alongside people who do not receive home and community-based services.

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

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

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

E. Beneficiaries receiving day habilitation services may also receive prevocational and/or individual supported employment services on the same day, but these services cannot be provided during the same time period or total more than five hours per day combined.

F. Service Exclusions

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

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

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

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

a. community living supports;

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

c. respite—out of home;

d. adult day health care;

e. monitored in-home caregiving (MIHC);

f. prevocational services; or

g. supported employment.

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

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

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

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2445 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2158 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1765 (December 2019), LR 47:1512 (October 2021), LR 48:1562 (June 2022).

§16309. Dental Services

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

1. adult diagnostic services;

2. preventative services;

3. restorative services;

4. endodontics;

5. periodontics;

6. prosthodontics;

7. oral and maxillofacial surgery;

8. orthodontics;

9. emergency care; and

10. adjunctive general services.

B. Dental Service Exclusions

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

2. services must first be exhausted prior to accessing ROW dental services. Non-covered services include but are not limited to the following:

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

b. dental care for cosmetic reasons;

c. experimental procedures;

d. plaque control;

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

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

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

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

i. dental expenses related to any dental services:

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

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

j. administration of in-office pre-medication.

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2445 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2159 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1512 (October 2021), LR 48:1563 (June 2022).

§16311. Environmental Accessibility Adaptations

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

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

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

1. performance of necessary assessments to determine the type(s) of modifications that are needed;

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

3. repair of equipment and/or devices, including battery purchases for vehicle lifts and other reoccurring replacement items that contribute to the ongoing maintenance of the approved adaptation(s); and

4. standard manufacturer provided service contracts and warranties.

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

1. The service must be for a specific approved adaptation.

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

D. Modifications may be applied to rental or leased property only with the written approval of the landlord and approval of OCDD.

E. All environmental accessibility adaptations to home and to a vehicle must meet all applicable standards of manufacture, design, and installation.

F. Service Exclusions for Home Adaptations

1. Home modification funds are not intended to cover basic construction cost. Waiver funds may only be used to pay the cost of purchasing specific approved adaptations for the home, not for the construction costs of additions to the home.

2. Home modifications shall not be furnished to adapt living arrangements that are owned or leased by paid caregivers or providers of waiver services.

3. Home modifications may not include modifications which add to the total square footage of the home, except when the additional square footage is necessary to make the required adaptions function appropriately.

EXAMPLE: if a bathroom is very small and a modification cannot be done without increasing the total square footage, this would be considered as an approvable cost.

a. When new construction or remodeling is a component of the service, payment for the service is to only cover the difference between the cost of typical construction and the cost of specialized construction.

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

a. flooring;

b. roof repair;

c. central air conditioning;

d. hot tubs;

e. swimming pools;

f. exterior fencing; or

g. general home repair and maintenance.

5. Home modification funds may not be used for service warranties and contracts above those provided by the manufacturer at the time of purchase (e.g., extended warranties, extended service contracts).

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

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

2. The service must be for a specific approved adaptation.

H. Service Exclusions for Vehicle Adaptations

1. Payment will not be made to:

a. adapt vehicles that are owned or leased by paid caregivers or providers of waiver services, or

b. purchase or lease of a vehicle.

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

3. Vehicle modification funds may not be used for regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications.

4. Car seats are not considered a vehicle adaptation.

5. Vehicle modification funds may not be used for service warranties and contracts above those provided by the manufacturer at the time of purchase (e.g., extended warranties, extended service contracts).

I. Provider Responsibilities

1. The environmental accessibility adaptation(s) must be delivered, installed, operational and reimbursed in the POC year in which it was approved.

2. A written itemized detailed bid, including drawings with the dimensions of the existing and proposed floor plans relating to the modifications, must be obtained and submitted for prior authorization.

3. Vehicle modifications must meet all of the applicable standards of manufacture, design and installation for all adaptations to the vehicle.

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

J. Provider Qualifications. In order to participate in the Medicaid Program, providers must meet the following qualifications.

1. Home Adaptations. Providers of environmental accessibility adaptations for the home must:

a. be registered through the State Licensing Board for Contractors as a home improvement contractor. The provider must have a current license from the State Licensing Board for Contractors for any of the following building trade classifications:

i. general contractor;

ii. home improvement; or

iii. residential building; or

b. If a current Louisiana Medicaid provider of durable medical equipment, have documentation from the manufacturing company (on its letterhead) that confirms that the provider is an authorized distributor of a specific product that attaches to a building. The letter must specify the product and state that the provider has been trained on its installation.

2. Vehicle Adaptations. Providers of environmental accessibility adaptations to vehicles must be licensed by the Louisiana Motor Vehicle Commission as a specialty vehicle dealer and accredited by the National Mobility Equipment Dealers Association under the Structural Vehicle Modifier category.

3. All environmental adaptations providers must comply with all applicable local (city or parish) occupational license(s).

4. All environmental adaptation providers, as well as the person performing the service (i.e., building contractors, plumbers, electricians, engineers, etc.), must meet any state or local requirements for licensure or certification. When state and local building or housing code standards are applicable, modifications to the home shall meet such standards, and all services shall be provided in accordance with applicable State or local requirements.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2446 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2159 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1513 (October 2021), LR 48:1563 (June 2022).

§16313. Host Home

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

home family members, including age, support needs, and privacy needs.

B. Host home services include assistance with:

1. personal care, assistance with the activities of daily living and adaptive living needs;

2. leisure activities, assistance to develop leisure interests and daily activities in the home setting;

3. social development/family inclusion, assistance to develop relationships with other members of the household; and

4. community inclusion supports in accessing community services and activities and pursuing and developing recreational and social interests outside the home.

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

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

1. arranging, training, and overseeing host home services (host home family);

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

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

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

D. Host home contractors are responsible for:

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

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

3. maintaining the beneficiary's documentation;

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

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

6. providing transportation as would a natural family member.

E. Host home contractors who serve children are required to provide daily supports and supervision on a 24-hour basis.

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

2. Support needs are based on the child's age, capabilities, health, and special needs.

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

F. Host home contractors serving adults are required to be available for daily supervision, support needs or emergencies as outlined in the adult beneficiary's POC based on medical, health and behavioral needs, age, capabilities and any special needs.

1. Host home contractors that serve adults who have been interdicted must ensure that services are furnished in accordance with the legal requirements of the interdiction.

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

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

I. Service Exclusions

1. Separate payment will not be made for community living supports since these services are integral to, and inherent in, the provision of host home services.

2. Payment will not be made for the following:

a. respite care services-out of home;

b. shared living/shared living conversion;

c. community living supports;

d. companion care;

e. monitored in-home caregiving (MIHC);

f. transportation-community access; or

g. one-time transition services.

3. The host home contractor may not be the same individual as the owner or administrator of the designated provider agency.

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

a. parent(s) of a minor child;

b. legal guardian of an adult or child with developmental disabilities;

c. parent(s) for an adult child, regardless of whether or not the adult child has been interdicted; or

d. spouse of the beneficiary.

5. Children eligible for Title IV-E services are not eligible for host home services.

6. Payment does not include room and board or maintenance, upkeep, or improvement of the host home family's residence.

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

J. Provider Qualifications

1. Home host service provider agencies must meet the following qualifications:

a. have experience in delivering therapeutic services to persons with developmental disabilities;

b. have staff who have experience working with persons with developmental disabilities;

c. screen, train, oversee and provide technical assistance to the host home family in accordance with OCDD requirements, including the coordination of an array of medical, behavioral and other professional services geared to persons with developmental disabilities (DD); and

d. provide on-going assistance to the host home family so that all HCBS waiver health and safety assurances, monitoring, and critical incident reporting requirements are met.

2. Agencies serving children must be licensed by the Department of Children and Family Services as a Class "A" Child Placing Agency under the Specialized Provider Licensing Act (R.S. 46:1401-46:1430), LAC 67:V.Chapter 73.

3. Agencies serving adults must be licensed by the Department of Health as a home and community-based services provider and meet the module requirements for substitute family care in LAC 48:I.Chapter 50.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2447 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2160 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1765 (December 2019), LR 47:1514 (October 2021), LR 48:1564 (June 2022).

§16319. One Time Transitional Services

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

B. One-time transitional services may be accessed for the following:

1. non-refundable security deposit;

2. utility deposits (set-up/deposit fee for telephone service);

3. essential furnishings to establish basic living arrangements, including:

a. bedroom furniture;

b. living room furniture;

c. tables and chairs;

d. window blinds; and

e. kitchen items (i.e., food preparation items, eating utensils, etc.);

4. moving expenses; and

5. health and safety assurances (i.e., pest eradication, one-time cleaning prior to occupancy, etc.).

C. Service Limits

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

2. Service expenditures will be prior authorized and tracked by the prior authorization contractor.

D. Service Exclusions

1. One-time transitional services may not be used to pay for the following:

a. housing, rent, or refundable security deposits; or

NOTE: Non-refundable security deposits are not to include rental payments.

b. furnishings or setting up living arrangements that are owned or leased by a waiver provider.

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

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

E. The Office for Citizens with Developmental Disabilities shall be the entity responsible for coordinating the delivery of one time transitional services. Providers must have a BHSF (Medicaid) provider enrollment agreement as a transition support provider as verified by Department of Health (LDH) Health Standards Section.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2449 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2162 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1766 (December 2019), LR 47:1516 (October 2021), LR 48:1565 (June 2022).

§16321. Personal Emergency Response System (PERS)

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

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

1. are able to identify when they are in an emergency situation and then able to activate the system requesting assistance; and

2. are unable to summon assistance by dialing 911 or other emergency services available to the general public.

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

D. Service Exclusions

1. Separate payment will not be made for shared living services.

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

E. Provider Qualifications

1. The provider must be authorized by the manufacturer to install and maintain equipment for personal emergency response systems.

2. Providers must comply with all applicable federal, state, county (parish), and local laws and regulations.

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

4. The provider's response center shall be staffed by trained professionals.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2249 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2162 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1516 (October 2021), LR 48:1565 (June 2022).

§16323. Prevocational Services

A. Prevocational services are individualized, person centered services that assist beneficiaries in establishing their path to obtain individualized community employment. This service is time limited and targeted for people who have an interest in becoming employed in individual jobs in the community but who may need additional skills, information, and experiences to determine their employment goal and to become successfully employed. Beneficiaries receiving prevocational services may choose to leave this service at any time or pursue employment opportunities at any time.

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

1. onsite prevocational services;

2. community career planning; and

3. virtual prevocational services.

C. Prevocational services are to be provided in a variety of locations in the community and are not to be limited to a fixed site facility. Activities associated with prevocational services should focus on preparing the beneficiary for integrated individual employment in the community. These services are operated through a provider agency that is licensed by the appropriate state licensing agency.

D. Beneficiaries receiving prevocational services must participate in activities designed to establish an employment goal. Prevocational services are designed to help create a path to integrated community-based employment for which a beneficiary is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Prevocational services may include assistance with personal care or with activities of daily living.

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

F. Service Limitations

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

a. Any time less than 15 minutes of service is not billable or payable.

b. No rounding up of units of service is allowed.

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

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

a. community living supports;

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

c. respite–out of home;

d. adult day healthcare;

e. monitored-in–home caregiving (MIHC);

f. day habilitation services; or

g. supported employment.

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

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

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

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

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

G. Restrictions

1. Beneficiaries receiving prevocational services may also receive day habilitation and/or individualized supported employment services, but these services cannot be provided during the same time period or total more than five hours per day combined.

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2450 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2162 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1766 (December 2019), LR 47:1516 (October 2021), LR 48:1565 (June 2022).

§16325. Professional Services

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

B. Professional services include services provided by the following licensed professionals:

1. occupational therapists;

2. physical therapists;

3. speech therapists;

4. registered dieticians;

5. social workers; and

6. psychologists.

C. Professional services can include:

1. assessments and/or re-assessments specific to the area of specialty with the goal of identifying status and developing recommendations, treatment, and follow-up;

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

3. intervening in a crisis situation with the goal of stabilizing and addressing issues related to the cause(s) of the crisis. Activities may include development of support plan(s), training, documentation strategies, counseling, on-call supports; back-up crisis supports, on-going monitoring, and intervention;

4. provide consultative services and recommendations as the need arises;

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

6. providing training and counseling services for natural supports and caregivers in a home setting with the goal of developing and maintaining healthy, stable relationships;

a. emphasis is placed on the acquisition of coping skills by building upon family strengths; and

b. services are intended to maximize the emotional and social adjustment and well-being of the individual, family, and caregiver;

7. providing nutritional services, including dietary evaluation and consultation with individuals or their care provider;

a. services are intended to maximize the individual's nutritional health;

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

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

NOTE: Psychologists and social workers will provide supports and services consistent with person-centered practices and Guidelines for Support Planning.

D. Service Exclusions

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

2. Children must access and exhaust services through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program prior to accessing waiver funds.

E. Provider Qualifications. The provider of professional services must be a Medicaid-enrolled provider. Each professional must possess a current valid Louisiana license to practice in his/her field and have at least one year of experience post licensure in his/her area of expertise.

1. Enrollment of individual practitioners. Individual practitioners who enroll as providers of professional services must:

a. have a current, valid license from the appropriate governing board of Louisiana for that profession; and

b. have a minimum of one year experience delivering services to persons with developmental disabilities.

c. In addition, the specific service delivered must be consistent with the scope of the license held by the professional.

2. Provider agency enrollment of professional services.

a. The following provider agencies may enroll to provide professional services:

i. a Medicare certified free-standing rehabilitation center;

ii. a licensed home health agency;

iii. a supervised independent living agency licensed by the department to provide shared living services;

iv. a substitute family care agency licensed by the department to provide host home services; or

v. a federally qualified health center (U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) grant recipient or Clinical Laboratory Improvement Amendments (CLIA) certificate holder.

b. Enrolled provider agencies may provide professional services by one of the following methods:

i. employing the professionals; or

ii. contracting with the professionals.

c. Provider agencies are required to verify that all professionals employed by or contracted with their agency meet the same qualifications required for individual practitioners as stated in §16325.E.1.a-c.

3. All professionals delivering professional services must meet the required one year of service delivery experience as defined by the following:

a. full-time experience gained in advanced and accredited training programs (i.e. master's or residency level training programs), which includes treatment services for persons with a developmental disability;

b. paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);

c. paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis – mental illness and a developmental disability); or

d. paid, full-time professional experience in specialized educational, vocational, and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

NOTE: Two years of part-time experience (minimum of 20 hours per week) may be substituted for one year of full-time experience.

4. The following activities do not qualify for the required experience:

a. volunteer professional experience; or

b. experience gained in caring for a relative or friend with a developmental disability.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2450 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2163 (October 2015), by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, amended LR 47:1518 (October 2021), LR 48:1566 (June 2022).

§16327. Respite Care Services–Out of Home

A. Respite care services–out of home are provided on a short-term basis to beneficiaries who are unable to care for themselves due to the absence of, or need for, relief of

caregivers who normally provide care and support. Services are provided by a center-based respite provider.

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

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

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

b. Transportation costs to and from these activities are included in the respite services-out of home rate.

B. Service Limits

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

2. The process for approving hours in excess of 720 hours must go through the established approval process with proper justification and documentation.

3. Federal financial participation (FFP) will be claimed for the cost of room and board only if it is provided as part of respite care furnished in a respite center approved by the state that is not a private residence.

C. Service Exclusions

1. Room and board shall be covered only if it is provided as part of respite care furnished in a state-approved facility that is not a private residence.

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

a. community living supports;

b. companion care;

c. host home;

d. shared living; or

e. monitored in-home caregiving (MIHC).

3. Respite care services-out of home cannot be provided in a personal residence.

4. Payment will not be made for transportation-community access.

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2451 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2164 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1767 (December 2019), LR 47:1519 (October 2021), LR 48:1566 (June 2022).

§16329. Shared Living Services

A. Shared living services are provided to a beneficiary in his/her home and community to achieve, improve, and/or maintain social and adaptive skills necessary to enable the beneficiary to reside in the community and to participate as independently as possible. Services are chosen by the beneficiary and developed in accordance with his/her goals and wishes with regard to compatibility, interests, age and privacy in the shared living setting.

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

a. 24-hour staff availability;

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

c. a daily schedule;

d. health and welfare needs;

e. transportation;

f. any non-residential ROW services delivered by the shared living services provider; and

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

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

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

a. self-care skills;

b. adaptive skills; and

c. leisure skills.

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

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

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

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

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

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

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

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

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

a. If the person has a legal guardian, the legal guardian's approval must also be obtained.

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

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

B. An ICF/IID may elect to permanently relinquish its ICF/IID license and all of its Medicaid facility need review approved beds from the total number of certificate of need (CON) beds for that home and convert it into a shared living waiver home or in combination with other ROW residential options as deemed appropriate in the approved conversion agreement.

1. In order to convert, provider request must be approved by the department and by OCDD.

2. ICF/IID residents who choose transition to a shared living waiver home must also agree to conversion of their residence.

3. If choosing ROW services, persons may select any ROW services and provider(s) based upon freedom of choice.

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

5. Shared living services are not located in a building that is a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or disability-specific housing complex. Shared living services are not provided in settings that are isolated from the larger community.

6. Family members who provide shared living services must meet the same standards as unrelated provider agency staff.

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

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

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

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

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

i. units have lockable entrance doors, with appropriate staff having keys to doors;

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

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

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

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

e. the setting is physically accessible to the beneficiary.

C. Shared Living Options

1. Shared Living Conversion Option. The shared living conversion option is only allowed for providers of homes which were previously licensed and Medicaid certified as an ICF/IID for up to a maximum of eight licensed and Medicaid-funded beds on October 1, 2009.

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

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

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

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

2. Shared Living Non-Conversion (New) Option. The shared living non-conversion option is allowed only for new or existing ICF/IID providers to establish a shared living waiver home for up to a maximum of three individuals.

a. The shared living waiver home must be located separate and apart from any ICF/IID.

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

c. The shared living waiver home must meet department's operational, programming and quality assurances for home and community-based services.

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

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

4. An ICF/IID provider who elects to convert to a shared living home via the shared living conversion process shall obtain the approval of all of the residents of the home(s) (or the responsible parties for these residents) regarding the conversion of the ICF/IID prior to beginning the process of conversion.

5. ICF/IID providers who elect to convert to a shared living home via the shared living conversion process shall submit a licensing application for a HCBS provider license, shared living module.

D. Service Exclusions and Limitations

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

2. Payments shall not be made for environmental accessibility adaptations when the provider owns or leases the residence.

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

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

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

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

a. community living supports;

b. respite care services-out of home;

c. companion care;

d. host home;

e. monitored in-home caregiving (MIHC);

f. transportation-community access; or

g. environmental accessibility adaptations (if housing is leased or owned by the provider).

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

8. The shared living services rate includes the cost of transportation.

a. The provider is responsible for providing transportation for all community activities except for vocational services.

b. Transportation for vocational services is included in the rate of the vocational service.

9. All Medicaid State Plan nursing services must be utilized and exhausted.

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

a. parent(s) of a minor child;

b. legal guardian of an adult or child with developmental disabilities;

c. parent(s) for an adult child regardless of whether or not the adult child has been interdicted; or

d. spouse of the beneficiary.

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

E. Provider Qualifications. Providers must be licensed by the Department of Health as a home and community-based services provider and meet the module requirements for supervised independent living and/or supervised independent living-conversion in LAC 48:I.Chapter 50.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2452 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2164 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1767 (December 2019), LR 47:1519 (October 2021), LR 48:1567 (June 2022).

§16333. Support Coordination

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

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

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

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

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

C. Service Limits

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

2. ROW will utilize support coordination for assisting with the moving of individuals from the institutions. Up to 90 consecutive days or per LDH policy, but not to exceed 180 days will be allowed for transition purposes.

a. Payment will be made upon certification and may be retroactive no more than 90 days or per LDH policy, but not to exceed 180 days prior to the certification date.

3. OCDD supports and services centers are prohibited from providing case management/support coordination services in the ROW.

D. Provider Qualifications. Providers must have a current, valid license as a case management agency and meet all other requirements for targeted case management services as set forth in case management, LAC 48:I.Chapter 49.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2453 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2165 (October 2015), by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, amended LR 47:1521 (October 2021), LR 48:1568 (June 2022).

§16335. Supported Employment

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

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

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

2. job assessment, discovery, and development; and

3. initial job support and job retention.

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

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

1. Transportation is payable only when a supported employment service is provided on the same day.

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

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

F. Supported employment services may be furnished by a coworker or other job-site personnel under the following circumstances:

1. the services furnished are not part of the normal duties of the coworker or other job-site personnel; and

2. these individuals meet the pertinent qualifications for the providers of service.

G. Service Limits. Beneficiaries may receive more than one type of vocational or habilitation service per day as long as the billing criteria is followed and as long as the requirements for the minimum time spent on site are adhered to. The required minimum number of service hours per day, per beneficiary are as follows.

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

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

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

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

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

1. Payment will only be made for the adaptations, supervision and training required by individuals receiving waiver services, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

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

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

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

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

b. Transportation is payable only when a supported employment service is provided on the same day.

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2453 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2166 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1767 (December 2019), LR 47:1521 (October 2021), LR 48:1569 (June 2022).

§16337. Transportation-Community Access

A. Transportation-community access services are provided to assist the beneficiary in becoming involved in his or her community. The service encourages and fosters the developmental of meaningful relationships in the community which reflects the beneficiary's choice and values. This service provides the beneficiary with a means of access to community activities and resources. The goal is to increase the beneficiary's independence, productivity, and community inclusion and to support self-directed employees benefits as outlined in the beneficiary's POC.

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

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

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

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

B. Service Limits

1. Community access trips are limited to no more than three round trips per day and must be arranged for geographic efficiency.

2. Greater than three trips per day require approval from the department or its designee.

C. Service Exclusions

1. Transportation-community access services shall not replace the following services:

a. transportation services to medically necessary services under the Medicaid State Plan;

b. transportation services provided as a means to get to and from school; or

c. transportation services to or from day habilitation, prevocational services, or supported employment services.

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

a. shared living;

b. host home; or

c. companion care.

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

4. Transportation-community access services may not be billed for the same day at the same time as community living supports.

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

1. In order to receive reimbursement for transporting Medicaid recipients to waiver services, family and friends must maintain compliance with the following:

a. state minimum automobile liability insurance coverage;

b. possess a current state inspection sticker; and

c. possess a current valid driver's license.

2. No special inspection by the Medicaid agency will be conducted.

3. Documentation of compliance with the three listed requirements for this class of provider must be submitted when enrollment in the Medicaid agency is sought. Acceptable documentation shall be the signed statement of the individual enrolling for payment that all three requirements are met.

a. The statement must also have the signature of two witnesses.

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2454 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2166 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1768 (December 2019), LR 47:1523 (October 2021), LR 48:1570 (June 2022).

§16339. Housing Stabilization Transition Services

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

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

a. access to housing;

b. meeting the terms of a lease;

c. eviction prevention;

d. budgeting for housing/living expenses;

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

f. home management;

g. establishing credit; and

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

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

a. arranging or providing transportation;

b. assisting in securing supporting documents/records;

c. completing/submitting applications;

d. securing deposits; and

e. locating furnishings;

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

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

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

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

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

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

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

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

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

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

D. Provider Qualifications. The permanent supportive housing (PSH) agency must be under contract and enrolled with the Department of Health statewide management organization for behavioral health services, and must also either:

1. meet the requirements for completion of the training program as verified by the PSH director; or

2. have at least one year of completion of housing support team experience in the PSH program as verified by the PSH director.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2169 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1523 (October 2021), LR 48:1570 (June 2022).

§16341. Housing Stabilization Services

A. Housing stabilization services enable waiver beneficiaries to maintain their own housing as set forth in the approved plan of care. Services must be provided in the home or a community setting. Housing stabilization services include the following components:

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

a. access to housing;

b. meeting the terms of a lease;

c. eviction prevention;

d. budgeting for housing/living expenses;

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

f. home management;

g. establishing credit; and

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

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

a. arranging or providing transportation;

b. assisting in securing supporting documents/records;

c. completing/submitting applications;

d. securing deposits; and

e. locating furnishings;

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

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

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

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

4. participating in the development of the plan of care, incorporating elements of the housing stabilization service provider plan, and in plan of care renewal and updates, as needed;

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

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

a. the beneficiary's disability;

b. accommodations needed; and

c. components of emergency procedures involving the landlord or property manager; and

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

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

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

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

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

D. Provider Qualifications. The permanent supportive housing (PSH) agency must be under contract and enrolled with the Department of Health and statewide management organization for behavioral health services, and must also either:

1. meet the requirements for completion of the training program as verified by the PSH director; or

2. have at least one year of completion of housing support team experience in the PSH program as verified by the PSH director.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2170 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1524 (October 2021), LR 48:1570 (June 2022).

§16343. Adult Day Health Care Services

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

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

1. medical care management;

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

3. assistance with activities of daily living;

4. health and nutrition counseling;

5. an individualized exercise program;

6. an individualized goal-directed recreation program;

7. health education classes;

8. individualized health/nursing services; and

9. meals. Meals shall not constitute a full nutritional regimen (three meals per day), but shall include a minimum of two snacks and a hot, nutritious lunch per day.

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

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

E. ADHC services shall be provided no more than 10 hours per day and no more than 50 hours per week.

F. The following services are not available to ADHC recipients:

1. monitored in-home caregiving (MIHC).

G. Provider Qualifications:

1. ADHC providers must be licensed according to the adult day health care provide licensing requirements contained in the Revised Statutes (R.S. 40:2120.41-40:2120.47).

2. ADHC providers must be enrolled as a Medicaid ADHC provider.

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

4. Qualifications for ADHC center staff are set forth in the *Louisiana Administrative Code*.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 42:62 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1768 (December 2019), LR 47:1524 (October 2021), LR 48:1571 (June 2022).

§16345. Monitored In-Home Caregiving Services

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

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

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

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

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

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

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

4. supervision or assistance with health related tasks (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 or accompanying the individual outside of the home to perform tasks, including instrumental activities of daily living, health maintenance or other needs as identified in the plan of care and to provide the same supervision or assistance as would be rendered in the home; and

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

C. Service Exclusions and Restrictions

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

a. community living supports (CLS);

b. companion care supports;

c. host home;

d. shared living supports; and

e. adult day health care services.

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

1. The agency provider must assess and approve the home in which services will be provided, and enter into contractual agreements with caregivers whom the agency has approved and trained.

2. The agency provider will pay per diem stipends to caregivers.

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

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

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

F. The department shall reimburse for monitored in-home caregiving services based on a two-tiered model which is designed to address the beneficiary's acuity.

G. Provider Qualifications

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1768 (December 2019), amended LR 47:1525 (October 2021), LR 48:1571 (June 2022).

Chapter 165. Self-Direction Initiative

§16501. Self-Direction Service Option

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

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

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

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

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

b. organizing the unique resources the beneficiary needs;

c. training beneficiaries on their employer responsibilities;

d. completing required forms for participation in self-direction;

e. back-up service planning;

f. budget planning;

g. verifying that potential employees meet program qualifications; and

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

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

1. be able to participate in the self-direction option without a lapse in or decline in quality of care or an increased risk to health and welfare;

2. complete the training programs (e.g., initial enrollment training) designated by OCDD; and

3. understand the rights, risks, and responsibilities of managing his or her own care and effectively managing his or her plan of care.

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

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

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

a. the application of a comprehensive monitoring strategy and risk assessment and management system; and

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

2. Waiver beneficiary's participation in the development and management of the approved personal purchasing plan.

a. This annual budget is determined by the recommended service hours listed in the beneficiary's POC to meet his needs.

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

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

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

a. best practices in recruiting, hiring, training, and supervising staff;

b. determining and verifying staff qualifications;

c. the process for obtaining criminal background checks on staff;

d. determining the duties of staff based on the service specifications;

e. determining the wages for staff within the limits set by the state;

f. scheduling staff and determining the number of staff needed;

g. orienting and instructing staff in duties;

h. best practices for evaluating staff performance;

i. verifying time worked by staff and approving timesheets;

j. terminating staff, as necessary;

k. emergency preparedness planning; and

l. back-up planning.

5. This training also includes a discussion on the differences between self-direction and other service delivery options (which includes the benefits, risks, and responsibilities associated with each service option) and the roles and responsibilities of the employer, support coordinator, and fiscal/employer agent.

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

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

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

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

a. Proper arrangements will be made by the support coordinator to ensure that there is no lapse in services.

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

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

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

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

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

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

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

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

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

iii. fails to follow the personal purchasing plan and the POC;

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

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

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

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

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

1. Employee Qualifications. All employees under the self-direction option must meet the qualifications for furnishing personal care services as set forth in LAC 48:I.Chapter 92.

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2455 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2167 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1525 (October 2021), LR 48:1572 (June 2022), LR 49:1727 (October 2023).

Chapter 167. Provider Participation

§16701. General Provisions

A. In order to participate in the Medicaid Program as a provider of services in the Residential Options Waiver, a provider must:

1. meet all of the requirements for licensure and the standards for participation in the Medicaid Program as a home and community-based services provider in accordance with state laws and the rules promulgated by the department;

2. comply with the regulations and requirements specified in LAC 50:XXI, Subparts 1 and 13 and the ROW provider manual;

3. comply with all of the state laws and regulations for conducting business in Louisiana, and when applicable, with the state requirements for designation as a non-profit organization; and

4. comply with all of the training requirements for providers of waiver services.

B. Providers must maintain adequate documentation to support service delivery and compliance with the approved POC and provide said documentation upon the department's request.

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

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

a. environmental accessibility adaptations;

b. personal emergency response systems; and

c. one-time transitional services.

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

D. If transportation is provided as part of a waiver service, the provider must comply with all of the state laws and regulations applicable to vehicles and drivers.

E. All services rendered shall be prior approved and in accordance with the POC.

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

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

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

G. Providers of ADHC services must:

1. be licensed as ADHC providers by the state of Louisiana in accordance with R.S. 40:2120.41-2120.47;

2. comply with all of the department's rules and regulations; and

3. be enrolled as an ADHC provider with the Medicaid program.

a. ADHC facility staff shall meet the requirements of department rules and regulations, as well as state licensing provisions.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2455 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2168 (October 2015), LR 42:63 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1527 (October 2021), LR 48:1573 (June 2022).

§16703. Staffing Restrictions and Requirements

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

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

1. Relatives must also comply with the following requirements:

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

b. become a Medicaid enrolled provider agency; or

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

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

ii. have a Medicaid provider agreement executed by the fiscal agent as authorized by the Medicaid agency.

2. Family members who may provide services include:

a. parents of an adult child;

b. siblings;

c. grandparents;

d. aunts, and uncles; and

e. cousins.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2168 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1527 (October 2021), LR 48:1573 (June 2022).

§16705. Electronic Visit Verification

A. Effective for dates of service on or after July 1, 2015, Residential Options 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 ROW provider manual.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:1287 (July 2015).

Chapter 169. Reimbursement

§16901. Unit of Reimbursement

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

1. respite care;

2. housing stabilization transition;

3. housing stabilization;

4. community living supports (CLS);

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

b. there is a separate reimbursement rate for CLS when these services are shared;

5. professional services furnished by a/an:

a. psychologist;

b. speech therapist;

c. physical therapist;

d. occupational therapist;

e. social worker;

f. registered dietician;

6. supported employment;

a. individual placement;

b. micro-enterprise;

7. adult day health care;

8. pre-vocational service; and

9. day habilitation.

EXCEPTION: The reimbursement for support coordination shall be at a fixed monthly rate and in accordance with the terms of the established contract.

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

1. environmental accessibility adaptations; and

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

2. assistive technology/specialized medical equipment and supplies.

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

1. host home;

2. companion care services;

3. shared living services;

a. per diem rates are established based on the number of individuals sharing the living service module for both shared living non-conversion and shared living conversion services; and

4. 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 reimbursement for transportation services is a flat fee based on a capitated rate.

E. Nursing services are reimbursed at either an hourly or per visit rate for the allowable procedure codes.

F. Installation of a personal emergency response system (PERS) is reimbursed at a one-time fixed rate and maintenance of the PERS is reimbursed at a monthly rate.

G. Transition expenses from an ICF/IID or nursing facility to a community living setting are reimbursed at the cost of the service(s) up to a lifetime maximum rate of $3,000.

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

I. The assessment performed by the monitored in-home caregiving provider shall be reimbursed at the authorized rate or approved amount of the assessment when the service has been prior authorized by the plan of care.

J. Reimbursement Exclusion. No payment will be made for room and board under this waiver program.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2456 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:1049 (April 2013), LR 41:2168, 2170 (October 2015), LR 42:63 (January 2016), LR 42:900 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2530 (December 2017), LR 45:1769 (December 2019), LR 47:1527 (October 2021), LR 48:1573 (June 2022).

§16903. Direct Service Worker Wages and Bonus Payments

A. Establishment of Direct Service Worker Wage Floor for Medicaid Home and Community-Based Services for Intellectual and Developmental Disabilities

1. Effective October 1, 2021, providers of Medicaid home and community-based waiver services operated through the Office for Citizens with Developmental Disabilities employing direct service workers will receive the equivalent of a $2.50 per hour rate increase.

2. Effective October 1, 2021, this increase or its equivalent will be applied to all service units provided by direct service workers with an effective date of service for the identified home and community based waiver services provided beginning October 1, 2021.

3. The minimum hourly wage floor paid to direct service workers shall be $9 per hour.

4. All providers of services affected by this rate increase shall be subject to a direct service worker wage floor of $9 per hour. This wage floor is effective for all affected direct service workers of any work status, whether full-time or part-time.

5. The Department of Health reserves the right to adjust the direct service worker wage floor as needed through appropriate rulemaking promulgation consistent with the Louisiana Administrative Procedure Act.

B. Establishment of Direct Service Worker Workforce Bonus Payments

1. Providers who provided services from April 1, 2021 to October 31, 2022 shall receive bonus payments of $300 per month for each direct service worker that worked with participants for those months.

2. The direct service worker who provided services to participants from April 1, 2021 to October 31, 2022 must receive at least $250 of this $300 bonus payment paid to the provider. This bonus payment is effective for all eligible direct service workers of any working status, whether full-time or part-time.

3. Bonus payments will end October 31, 2022.

4. LDH reserves the right to adjust the amount of the bonus payments paid to the direct service worker as needed through appropriate rulemaking promulgation consistent with the Administrative Procedure Act.

C. Audit Procedures for Direct Service Worker Wage Floor and Workforce Bonus Payments

1. The wage enhancement and bonus payments reimbursed to providers shall be subject to audit by LDH.

2. Providers shall provide to LDH or its representative all requested documentation to verify that they are in compliance with the direct service worker wage floor and bonus payments.

3. This documentation may include, but is not limited to, payroll records, wage and salary sheets, check stubs, etc.

4. Providers shall produce the requested documentation upon request and within the timeframe provided by LDH.

5. Non-compliance or failure to demonstrate that the wage enhancement and/or bonus payments were paid directly to direct service workers may result in the following:

a. sanctions; or

b. disenrollment from the Medicaid Program.

D. Sanctions for Direct Service Worker Wage Floor and Workforce Bonus Payments

1. The provider will be subject to sanctions or penalties for failure to comply with this Rule or with requests issued by LDH pursuant to this Rule. The severity of such action will depend upon the following factors:

a. Direct Service Worker Wage Floor

i. failure to pay I/DD HCBS direct service workers the wage floor minimum of $9 per hour;

ii. the number of I/DD HCBS direct service workers identified as having been paid less than the wage floor minimum of $9 per hour; or

iii. the persistent failure to pay I/DD HCBS direct service workers the wage floor minimum of $9 per hour;

b. Direct Service Worker Workforce Bonus Payments

i. failure to pay eligible I/DD HCBS direct service workers the $250 monthly workforce bonus payments;

ii. the number of eligible I/DD HCBS direct service workers who are identified as having not been paid the $250 monthly workforce bonus payments; or

iii. the persistent failure to pay wage eligible I/DD HCBS direct service workers the $250 monthly workforce bonus payments; or

c. failure to provide LDH with any requested documentation or information related to or for the purpose of verifying compliance with this Rule.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2456 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2169 (October 2015), LR 42:900 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities LR 48:42R (January 2022), LR 49:1071 (June 2023).