

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

Bruce D. Greenstein  
Secretary

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## RULE

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

Home and Community-Based Services Waivers  
Community Choices Waiver  
(LAC 50:XXI.Chapters 81-95)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services have repealed and replaced LAC 50:XXI.Chapters 81-91 and have adopted LAC 50:XXI.Chapters 93-95 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq.

## Title 50

### PUBLIC HEALTH-MEDICAL ASSISTANCE Part XXI. Home and Community-Based Services Waivers

#### Subpart 7. Community Choices Waiver

#### Chapter 81. General Provisions

##### §8101. Introduction

A. The target population for the Community Choices Waiver includes individuals who:

1. are currently in the Elderly and Disabled Adults Waiver as of September 30, 2011;
2. are 65 years of age or older; or
3. are 21-64 years of age with a physical disability; and
4. meet nursing facility level of care requirements.

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

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

1. an individual requestor/applicant;
2. an individual who is legally responsible for a requestor/applicant; or
3. a responsible representative designated by the requestor/applicant to act on his/her behalf.

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

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

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

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

2. The functions of a responsible representative are to:

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

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

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

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

##### §8103. Request for Services Registry

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

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

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

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

##### §8105. Programmatic Allocation of Waiver Opportunities

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

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

1. individuals with substantiated cases of abuse or neglect referred by Adult Protective Services (APS) or Elderly Protective Services (EPS) who, without Community Choices Waiver services, would require institutional placement to prevent further abuse or neglect;

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

3. individuals admitted to a nursing facility who are approved for a stay of more than 90 days;

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

- a. Adult Day Health Care (ADHC) Waiver;
- b. New Opportunities Waiver (NOW);
- c. Supports Waiver, and/or
- d. Residential Options Waiver (ROW); and

5. all other eligible individuals on the Request for Services Registry (RFSR), by date of first request for services.

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

D. Notwithstanding the priority group provisions, 75 Community Choices Waiver opportunities are reserved for qualifying individuals who have been diagnosed with Amyotrophic Lateral Sclerosis (ALS). Qualifying individuals who have been diagnosed with ALS shall be offered an opportunity on a first-come, first-serve basis.

E. Notwithstanding the priority group provisions, up to 100 EDA Waiver opportunities may be granted to qualified individuals who require emergency waiver services. These individuals shall be offered an opportunity on a first-come, first-serve basis.

1. To be considered for an emergency waiver opportunity, the individual must, at the time of the request for the emergency opportunity, be approved for the maximum amount of services allowable under the Long Term Personal Care Services Program and require institutional placement, unless offered an emergency waiver opportunity.

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

- a. support through other programs is either unavailable or inadequate to prevent nursing facility placement;
- b. the death or incapacitation of an informal caregiver leaves the person without other supports;
- c. the support from an informal caregiver is not available due to a family crisis; or
- d. the person lives alone and has no access to informal support.

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

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

#### **§8107. Resource Assessment Process**

A. Each Community Choices Waiver applicant/participant shall be assessed using a uniform assessment tool called the Minimum Data Set-Home Care (MDS-HC). The MDS-HC is designed to verify that an individual meets nursing facility level of care and to assess multiple key domains of function, health, social support and service use. The MDS-HC assessment generates a score that assigns the individual to a Resource Utilization Group (RUG-III/HC).

B. The following seven primary RUG-III/HC categories and subcategories will be utilized to determine the assistance needed for various activities of daily living (ADLs) and instrumental activities of daily living (IADLs):

1. Special Rehabilitation. Individuals in this category have had at least 120 minutes of rehabilitation therapy (physical, occupational and/or speech) within the seven days prior to their MDS-HC assessment.

2. Extensive Services. Individuals in this category have a medium to high level of need for assistance with ADLs and require one or more of the following services:

- a. tracheostomy;
- b. ventilator or respirator; or
- c. suctioning.

3. Special Care. Individuals in this category have a medium to high level of need for assistance with ADLs and have one or more of the following conditions or require one or more of the following treatments:

- a. stage 3 or 4 pressure ulcers;
- b. tube feeding;
- c. multiple sclerosis diagnosis;
- d. quadriplegia;
- e. burn treatment;
- f. radiation treatment;
- g. IV medications; or
- h. fever and one or more of the following conditions:
  - i. dehydration diagnosis;
  - ii. pneumonia diagnosis;
  - iii. vomiting; or
  - iv. unintended weight loss.

4. Clinically Complex. Individuals in this category have the following specific clinical diagnoses or require the specified treatments:

- a. dehydration;
- b. any stasis ulcer. A stasis ulcer is a breakdown of the skin caused by fluid build-up in the skin from poor circulation;
- c. end-stage/terminal illness;
- d. chemotherapy;
- e. blood transfusion;
- f. skin problem;
- g. cerebral palsy diagnosis;
- h. urinary tract infection;
- i. hemiplegia diagnosis. Hemiplegia diagnosis shall include a total or partial inability to move, experienced on one side of the body, caused by brain disease or injury;
- j. dialysis treatment;
- k. diagnosis of pneumonia;
- l. one or more of the eight criteria in special care (with low ADL need); or
- m. one or more of the three criteria in extensive services (with low ADL need).

5. Impaired Cognition. Individuals in this category have a low to medium need for assistance with ADLs and impairment in cognitive ability. This category includes individuals with short-term memory loss, trouble in decision-making, difficulty in making themselves understood by others and difficulty in eating performance.

6. Behavior Problems. Individuals in this category have a low to medium need for assistance with ADLs and

behavior problems. This category includes individuals that may have socially inappropriate behavior, are physically or verbally abusive, have hallucinations or exhibit wandering behavior.

7. Reduced Physical Function. Persons in this category do not meet the criteria in one of the previous six categories.

C. Based on the RUG III/HC score, the applicant/participant is assigned to a level of support category and is eligible for a set annual services budget associated with that level.

1. If the applicant/participant disagrees with his/her annual services budget, the applicant/participant or his/her responsible representative may request a fair hearing to appeal the decision.

2. The applicant/participant may qualify for an increase in the annual services budget amount upon showing that:

a. one or more answers are incorrect as recorded on the MDS-HC (except for the answers in Sections AA, BB, A, and R); or

b. he/she needs an increase in the annual services budget to avoid entering into a nursing facility.

D. Each Community Choices Waiver participant shall be re-assessed at least annually.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3518 (December 2011).

### **Chapter 83. Covered Services**

#### **§8301. Support Coordination**

A. Support coordination is services that will assist participants in gaining access to needed waiver and other State Plan services, as well as needed medical, social, educational, housing, and other services, regardless of the funding source for these services. Support coordinators shall be responsible for ongoing monitoring of the provision of services included in the participant's approved plan of care (POC) as well as:

1. evaluation and/or re-evaluation of the level of care;
2. assessment and/or re-assessment of the need for waiver services;
3. development and/or review of the service plan;
4. coordination of multiple services and/or among multiple providers;
5. linking waiver participants to other federal, state and local programs;
6. monitoring the implementation of the service plan and participant health and welfare;
7. addressing problems in service provision;
8. responding to participant crises; and
9. determining the cost neutrality of waiver services for an individual.

B. Support coordinators shall provide information and assistance to waiver participants in directing and managing their services. When participants choose to self-direct their waiver services, the support coordinators are responsible for reviewing the *Self-Direction Employer Handbook* with participants who have elected this option for service delivery. Support coordinators shall be available to participants for on-going support and assistance in these decision-making areas and with employer responsibilities.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3519 (December 2011).

#### **§8303. Transition Intensive Support Coordination**

A. Transition intensive support coordination is services that will assist participants who are currently residing in nursing facilities in gaining access to needed waiver and other state plan services, as well as needed medical, social, housing, educational and other services, regardless of the funding source for these services. Support coordinators shall initiate and oversee the process for assessment and reassessment, as well as be responsible for ongoing monitoring of the provision of services included in the participant's approved POC.

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

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

B. Support coordinators may assist persons to transition for up to 180 days while the individual still resides in the facility.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3519 (December 2011).

#### **§8305. Environmental Accessibility Adaptations**

A. Environmental accessibility adaptations are necessary physical adaptations that will be made to the home to reasonably assure the health and welfare of the participant, or enable the participant to function with greater independence in the home. Without these necessary adaptations, the participant would require institutionalization.

1. There must be an identified need for environmental accessibility adaptations as indicated by the MDS-HC.

a. Once identified by MDS-HC, a credential assessor must verify the need for, and draft specifications for, the environmental accessibility adaptation(s).

b. A credentialed assessor must ensure that the environmental accessibility adaptation(s) meets all specifications before payment shall be made to the contractor that performed the environmental accessibility adaptation(s).

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3519 (December 2011).

#### **§8307. Personal Assistance Services**

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

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

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

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

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

5. supervision or assistance while escorting/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 POC and to provide the same supervision or assistance as would be rendered in the home; and

6. extension of therapy services, defined as follows:

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

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

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

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

D. Participants who receive PAS cannot receive long-term personal care services.

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

1. a minimum of 1 hour and a maximum of 2 hours of PAS provided to assist the participant at the beginning of his/her day, referred to as the "a.m." portion of this PAS delivery method; and

2. a minimum of 1 hour and a maximum of 2 hours to assist the participant at the end of his/her day, referred to as the "p.m." portion of this PAS delivery method; and

3. a minimum 4 hours break between the "a.m." and the "p.m." portions of this PAS delivery method; and

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

5. "A.m. and p.m." PAS may not be provided on the same calendar day as other PAS delivery methods.

6. It is permissible to receive only the "a.m." or "p.m." portion of PAS within a calendar day. However, "a.m." PAS may not be provided on the same calendar day as other PAS delivery methods.

F. PAS may be provided by one worker for up to three waiver participants who live together and who have a common direct service provider. Waiver participants may

share PAS staff when agreed to by the participants and as long as the health and welfare of each participant can be reasonably assured. Shared PAS is to be reflected in the POC of each participant. Reimbursement rates shall be adjusted accordingly.

G. A home health agency direct service worker who renders personal assistance services must be a qualified home health aide as specified in Louisiana's Minimum Licensing Standards for Home Health Agencies.

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

I. Every PAS provider shall ensure timely completion of the OAAS Emergency Plan and Agreement Form for each waiver participant they serve in accordance with OAAS Policy.

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

1. the participant's spouse;

2. the participant's curator;

3. the participant's tutor;

4. the participant's legal guardian;

5. the participant's responsible representative; or

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

K. Participants are not permitted to receive PAS while living in a home or property owned, operated, or controlled by a provider of services who is not related by blood or marriage to the participant.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3519 (December 2011).

### **§8309. Transition Services**

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

B. Allowable expenses are those necessary to enable the individual to establish a basic household, excluding expenses for room and board, but includes:

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

2. specific set up fees or deposits (telephone, electric, gas, water and other such necessary housing set up fees or deposits);

3. essential furnishings to establish basic living arrangements; and

4. health and welfare assurances (pest control/eradication, fire extinguisher, smoke detector and first aid supplies/kit).

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

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

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

F. Funds are available one time per \$1500 lifetime maximum for specific items as prior approved in the participant's POC.

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

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

### **§8311. Adult Day Health Care Services**

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

B. ADHC Services include:

1. meals, which shall not constitute a "full nutritional regimen" (3 meals per day) but will include 2 snacks and a hot nutritious lunch;

2. transportation between the participant's place of residence and the ADHC;

3. assistance with activities of daily living;

4. health and nutrition counseling;

5. individualized exercise program;

6. individualized goal-directed recreation programs;

7. health education classes; and

8. individualized health/nursing services.

C. ADHC services may be provided no more than 10 hours per day and no more than 50 hours per week.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3521 (December 2011).

### **§8313. Caregiver Temporary Support Services**

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

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

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

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

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

2. nursing facilities;

3. assisted living facilities;

4. respite centers; or

5. adult day health care centers.

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

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3521 (December 2011).

### **§8315. Assistive Devices and Medical Supplies**

A. Assistive devices and medical supplies are specialized medical equipment and supplies which include devices, controls, appliances, or nutritional supplements specified in the POC that enable individuals to:

1. increase or maintain their abilities to perform activities of daily living; or

2. to perceive, control, or communicate with the environment in which they live or provide emergency response.

B. This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of assistive devices, and durable and non-durable medical equipment. This service includes personal emergency response systems (PERS) and other in-home monitoring and medication management devices and technology.

C. This service may also be used for routine maintenance or repair of specialized equipment. Batteries, extended warranties, and service contracts that are cost effective may be reimbursed. This includes medical equipment not available under the state plan that is necessary to address participant functional limitations and necessary medical supplies not available under the state plan that are addressed in the POC.

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

E. All services must be based on a verified need of the participant and the service must have a direct or remedial benefit to the participant with specific goals and outcomes. This benefit must be determined by an independent assessment on any items whose cost exceeds \$500 and on all communication devices, mobility devices, and environmental controls. Independent assessments are done by the appropriate professional, *e.g.*, an occupational therapist, physical therapist, and/or speech-language pathologist, who has no fiduciary relationship with the manufacturer, supplier, or vendor of the item.

F. All items must reduce reliance on other Medicaid State Plan or waiver services.

G. All items must meet applicable standards of manufacture, design, and installation.

H. All items must be prior authorized and no experimental items shall be authorized.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3521 (December 2011).

#### **§8317. Home Delivered Meals**

A. The purpose of home delivered meals is to assist in meeting the nutritional needs of an individual in support of the maintenance of self-sufficiency and enhancing the quality of life.

B. Up to two nutritionally balanced meals per day may be delivered to the home of an eligible participant who is unable to leave his/her home without assistance, unable to prepare his/her own meals, and/or has no responsible caregiver in the home.

C. Each meal shall provide a minimum of one-third of the current recommended dietary allowance (RDA) for the participant as adopted by the United States Department of Agriculture. The provision of home delivered meals does not provide a full nutritional regimen.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3522 (December 2011).

#### **§8319. Non-Medical Transportation**

A. Non-medical transportation is a service offered to enable waiver participants to participate in normal life activities pertaining to the IADLs cited in the POC and includes activities needed to facilitate transition to the community.

B. Waiver transportation services may not be used to:

1. replace unpaid caregivers, volunteer transportation, and other transportation services available to the individual;
2. replace services that are included in a service provider's reimbursement;
3. obtain items that can be delivered by a supplier or by mail-order; or
4. compensate the service provider for travel to or from the service provider's home.

C. This service shall be offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the state plan, defined at 42 CFR §440.170(a) (if applicable), and shall not replace them.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3522 (December 2011).

#### **§8321. Nursing Services**

A. Nursing services are services that are medically necessary and may only be provided efficiently and effectively by a nurse practitioner, registered nurse, or a licensed practical nurse working under the supervision of a registered nurse. The nursing services provided must be within the scope of the Louisiana statutes governing the practice of nursing.

B. Nursing services may include periodic assessment of the participant's medical condition when the condition requires a skilled nurse to identify and evaluate the need for medical intervention or to monitor and/or modify the medical treatment services provided by non-professional care providers.

C. Services may also include regular, ongoing monitoring of a participant's fragile or complex medical condition as well as the monitoring of a participant with a history of noncompliance with medication or other medical treatment needs.

D. Nursing may also be used to assess a participant's need for assistive devices or home modifications, training the participant and family members in the use of the purchased devices, and training of direct service workers in tasks necessary to carry out the POC.

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

F. All services must be based on a verified need of the participant. The service must have a direct or remedial benefit to the participant with specific goals and outcomes.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3522 (December 2011).

#### **§8323. Skilled Maintenance Therapy**

A. Skilled maintenance therapy is therapy services that may be received by Community Choices Waiver participants in the home or in a rehabilitative center. Unlike State Plan therapy services, provision of therapy services under the Community Choices Waiver expands the provider base to rehabilitative centers and individually licensed therapists so that participants may receive maintenance therapies either at home, work, or at a rehabilitative center in order to increase access to therapy services.

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

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

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

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

F. Skilled maintenance therapy services specifically include:

1. physical therapy services which promote the maintenance of, or the reduction in, the loss of gross/fine

motor skills, and facilitate independent functioning and/or prevent progressive disabilities including:

- a. professional assessment(s), evaluation(s) and monitoring for therapeutic purposes;
- b. physical therapy treatments and interventions;
- c. training regarding physical therapy activities, use of equipment and technologies;
- d. designing, modifying or monitoring the use of related environmental modifications;
- e. designing, modifying, and monitoring the use of related activities supportive to the POC goals and objectives; or
- f. consulting or collaborating with other service providers or family members, as specified in the POC;

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

- a. teaching of daily living skills;
- b. development of perceptual motor skills and sensory integrative functioning;
- c. design, fabrication, or modification of assistive technology or adaptive devices;
- d. provision of assistive technology services;
- e. design, fabrication, or applying selected orthotic or prosthetic devices or selecting adaptive equipment;
- f. use of specifically designed crafts and exercise to enhance function;
- g. training regarding OT activities; and
- h. consulting or collaborating with other service providers or family members, as specified in the POC;

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

- a. identification of communicative or oropharyngeal disorders;
- b. prevention of communicative or oropharyngeal disorders;
- c. development of eating or swallowing plans and monitoring their effectiveness;
- d. use of specifically designed equipment, tools, and exercises to enhance function;
- e. design, fabrication, or modification of assistive technology or adaptive devices;
- f. provision of assistive technology services;
- g. adaptation of the participant's environment to meet his/her needs;
- h. training regarding SLT activities; and
- i. consulting or collaborating with other service providers or family members, as specified in the POC; and

4. respiratory therapy services which provide preventative and maintenance airway-related techniques and procedures including:

- a. application of medical gases, humidity and aerosols;
- b. intermittent positive pressure;
- c. continuous artificial ventilation;
- d. administration of drugs through inhalation and related airway management;

- e. individual care;
- f. instruction administered to the waiver participant and informal supports; and
- g. periodic management of ventilation equipment for participants whose ventilation care is performed by informal caregivers.

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3522 (December 2011).

## **Chapter 85. Self-Direction Initiative**

### **§8501. Self-Direction Service Option**

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

B. Participant Responsibilities. Waiver participants choosing the self-directed services option must understand the rights, risks, and responsibilities of managing their own care and individual budget. If the participant is unable to make decisions independently, he/she must have a responsible representative who understands the rights, risks, and responsibilities of managing his/her care and supports within his/her individual budget.

C. Termination of the 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. A waiver participant may choose at any time to withdraw from the self-direction service option and return to the traditional provider agency management of services.

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

- a. the health or welfare of the participant is compromised by continued participation in the self-directed option;
- b. the participant is no longer able to direct his/her own care and there is no responsible representative to direct the care;
- c. there is misuse of public funds by the participant or the responsible representative; or

- d. the participant or responsible representative:
  - i. places barriers to the payment of the salaries and related state and federal payroll taxes of direct support staff;
  - ii. fails to follow the POC;
  - iii. fails to provide required documentation of expenditures and related items; or
  - iv. fails to cooperate with the fiscal agent or support coordinator in preparing any additional documentation of expenditures.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3523 (December 2011).

#### **Chapter 87. Plan of Care**

##### **§8701. Plan of Care**

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

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

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

1. types and number of services (including waiver and all other services) necessary to reasonably assure health and welfare and to maintain the person in the community;
2. individual cost of each service (including waiver and all other services); and
3. the total cost of services covered by the POC.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3524 (December 2011).

#### **Chapter 89. Admission and Discharge Criteria**

##### **§8901. Admission Criteria**

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

1. meets the target population criteria as specified in the approved waiver document;
2. initial and continued Medicaid eligibility;
3. initial and continued eligibility for a nursing facility level of care;
4. justification, as documented in the approved POC, that the Community Choices Waiver services are appropriate, cost effective and represent the least restrictive environment for the individual; and
5. reasonable assurance that the health and welfare of the participant can be maintained in the community with the provision of Community Choices Waiver services.

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3524 (December 2011).

##### **§8903. Admission Denial or Discharge Criteria**

A. Admission shall be denied or the participant shall be discharged from the Community Choices Waiver Program if any of the following conditions are determined.

1. The individual does not meet the target population criteria as specified in the approved waiver document.
2. The individual does not meet the criteria for Medicaid eligibility.
3. The individual does not meet the criteria for a nursing facility level of care.
4. The participant resides in another state or has a change of residence to another state.
5. Continuity of services is interrupted as a result of the participant not receiving and/or refusing Community Choices Waiver services (exclusive of support coordination services) for a period of 30 consecutive days.
6. The health and welfare of the individual cannot be reasonably assured through the provision of Community Choices Waiver services.
7. The individual fails to cooperate in the eligibility determination process or in the performance of the POC.
8. Failure on behalf of the individual to maintain a safe and legal home environment.
9. It is not cost effective or appropriate to serve the individual in the Community Choices Waiver.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3524 (December 2011).

#### **Chapter 91. Waiver Cost Neutrality**

##### **§9101. Waiver Costs Limit**

A. The annual service budget for each of the RUG-III/HC groups shall be reviewed to ensure that the costs of the Community Choices Waiver remain within applicable federal rules regarding the cost-effectiveness of the waiver. To ensure cost-effectiveness, the mean expenditures across all RUG-III/HC categories must be less than or equal to the average cost to the state of providing care in a nursing facility. If the waiver is not cost-effective, the annual service budgets for some or all RUG-III/HC groups shall be reduced to bring the waiver into compliance.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3524 (December 2011).

#### **Chapter 93. Provider Responsibilities**

##### **§9301. General Provisions**

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

B. The provider agrees to not request payment unless the participant for whom payment is requested is receiving

services in accordance with the Community Choices Waiver Program provisions and the services have actually been provided.

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

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3524 (December 2011).

#### **§9303. Reporting Requirements**

A. Support coordinators and direct service providers are obligated to report any changes to the department that could affect the waiver participant's eligibility including, but not limited to, those changes cited in the denial or discharge criteria.

B. Support coordinators and direct service providers are responsible for documenting the occurrence of incidents or accidents that affect the health and welfare of the participant and for completing an incident report. The incident report shall be submitted to the department or its designee with the specified 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, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3525 (December 2011).

### **Chapter 95. Reimbursement**

#### **§9501. Reimbursement Methodology**

A. Reimbursement for the following services shall be a prospective flat rate for each approved unit of service provided to the participant. One quarter hour (15 minutes) is the standard unit of service, which covers both the service provision and administrative costs for the following services:

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

a. personal assistance services furnished to one participant shall be reimbursed at 100 percent of the full rate for the participant;

b. personal assistance services furnished to two participants shall be reimbursed at 75 percent of the full rate for each participant;

c. personal assistance services furnished to three participants shall be reimbursed at 66 percent of the full rate for each participant;

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

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

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

1. environmental accessibility adaptations;

2. assistive devices and medical supplies;

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

4. transition expenses up to a lifetime maximum of \$1500.

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

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

a. assisted living providers;

b. nursing facility; or

c. respite center.

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

1. support coordination; and

2. transition intensive support coordination.

E. Non-medical transportation is reimbursed per one-way trip at a fee established by OAAS.

F. Certain nursing and skilled maintenance therapy procedures as well as personal assistance services furnished via "a.m. and p.m." delivery method will be reimbursed on a per-visit basis.

G. Certain environmental accessibility adaptation, nursing, and skilled maintenance therapy procedures will be reimbursed on a per-service basis.

H. Adult day health care services shall be reimbursed a per quarter hour rate for services provided under a prospective payment system (PPS). The system shall be designed in a manner that recognizes and reflects the cost of direct care services provided. The reimbursement methodology is designed to improve the quality of care for all Community Choices Waiver participants by ensuring that direct care services are provided at an acceptable level while fairly reimbursing the providers.

I. Reimbursement shall not be made for Community Choices Waiver services provided prior to the department's approval of the POC.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3525 (December 2011).

#### **§9503. Direct Support Professionals Wage Enhancement**

A. An hourly wage enhancement payment in the amount of \$2 shall be reimbursed to providers for full-time equivalent (FTE) direct support professionals who provide home and community-based waiver services to Community Choices Waiver participants. Direct support professionals are persons who deliver direct care services such as assistance with the activities of daily living.

1. At least 75 percent of the wage enhancement shall be paid in the aggregate to the direct support professionals as wages. If less than 100 percent of the enhancement is paid in

wages, the remainder, up to 25 percent shall be used to pay employer-related taxes, insurance and employee benefits.

B. The minimum hourly rate paid to direct support professionals shall be the federal minimum wage in effect on October 1, 2011 plus 75 percent of the wage enhancement or the current federal minimum wage, whichever is higher.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3525 (December 2011).

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

Bruce D. Greenstein  
Secretary

1112#096

#### **RULE**

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

Home and Community-Based Services Waivers  
New Opportunities Waiver  
Allocation of Waiver Opportunities for ICF-DD Transitions  
(LAC 50:XXI.13707)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:XXI.13707 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

#### **Title 50**

**PUBLIC HEALTH—MEDICAL ASSISTANCE  
Part XXI. Home and Community Based Services  
Waivers**

#### **Subpart 11. New Opportunities Waiver**

#### **Chapter 137. General Provisions**

#### **§13707. Programmatic Allocation of Waiver Opportunities**

A. - C.2. ...

3. Except for those waiver opportunities addressed in Paragraphs C.1, 2, 6 and 7, waiver opportunities vacated during the waiver year shall be made available to persons residing in or leaving any publicly operated ICF-DD at the time the facility is transferred to any private ICF-DD under a cooperative endeavor agreement with OCDD, or their alternates.

C.4. - D. ...

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

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

with Developmental Disabilities, LR 31:2900 (November 2005), amended LR 33:2440 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 37:3526 (December 2011).

Bruce D. Greenstein  
Secretary

1112#097

#### **RULE**

**Department of Natural Resources  
Office of Conservation  
Environmental Division**

Water Well Construction—Location  
(LAC 56:1.321)

The Louisiana Office of Conservation has amended LAC 56:1.Chapter 3, Section 321 in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and pursuant to the power delegated under the laws of the state of Louisiana. The proposed amendment will require protective corner posts around certain drilling rig supply water wells.

#### **Title 56**

#### **PUBLIC WORKS**

#### **Part I. Water Wells**

#### **Chapter 3. Water Well Construction**

#### **§321. Location in Relation to Buildings and Other Structures**

A. A well shall be located far enough from a building to allow reworking or rehabilitation with a drilling rig. A well shall not be located below ground surface, such as in pits and basements, and shall not be located within the foundation of a building, except a building constructed solely to house pumping and water system equipment.

B. For drilling rig supply wells, if the well is located on the constructed work pad for drilling operations or within the ring levee system, it must be surrounded with four protective corner posts. If the well is located outside the ring levee system and will be transferred for some other future use or will not be plugged and abandoned within six months of completion of associated oil and gas well drilling activity, it must be surrounded by four protective corner posts. The corner posts shall be constructed of four inch diameter metal pipe not less than schedule 40 and shall be concreted below the ground surface not less than four feet and shall extend above the ground surface not less than three feet.

AUTHORITY NOTE: Promulgated in accordance with R.S. 38:3091-R.S. 38:3098.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, Office of Public Works, LR 1:249 (May 1975), amended LR 11:954 (October 1985), repromulgated by the Department of Transportation and Development, Office of Public Works, LR 31:942 (April 2005), amended LR 37:3526 (December 2011).

James H. Welsh  
Commissioner

1112#026