

Bobby Jindal
GOVERNOR



Bruce D. Greenstein
SECRETARY

State of Louisiana
Department of Health and Hospitals
Office of the Secretary

January 16, 2012

The Honorable John A. Alario, Jr., President
Louisiana State Senate
P.O. Box 94183, Capitol Station
Baton Rouge, LA 70804-9183

The Honorable Charles E. Kleckley, Speaker
Louisiana State House of Representatives
P.O. Box 94062, Capitol Station
Baton Rouge, LA 70804-9062

The Honorable Scott M. Simon, Chairman
House Health and Welfare Committee
Louisiana State House of Representatives
P.O. Box 44486, Capitol Station
Baton Rouge, LA 70804-4486

The Honorable David Heitmeier, Chairman
Senate Health and Welfare Committee
Louisiana State Senate
P.O. Box 94183, Capitol Station
Baton Rouge, LA 70804-9183

Dear President Alario, Speaker Kleckley, and Honorable Chairs:

In response to Act 299 of the 2011 Regular Session, the Louisiana Department of Health and Hospitals (DHH) submits the enclosed report. Act 299 requires DHH to develop a comprehensive plan to address the delivery of quality services provided to individuals receiving home and community based services (HCBS) and to submit a report to the House and Senate health and welfare committees.

Promoting independence through community-based care is a strategic priority in DHH's business plan, and this report draws on the efforts currently underway to improve HCBS programs. In order to meet the requirements of Act 299, representatives from the Office of Aging and Adult Services (OAAS), the Office for Citizens with Developmental Disabilities (OCDD), and several stakeholder groups worked together to develop action steps, recommended time lines, and necessary resources for implementation on all elements of the plan.

The Louisiana ARC, AARP, Families Helping Families, and HCBS program participants, among others, served on subcommittees with DHH staff to meet and report on the following HCBS issues, as directed by Act 299: provider accreditation, compliance, billing, cost reporting, support coordination, rate reimbursement, technology, Medicaid enrollment, and Medicaid delivery options. The enclosed report describes in detail each element of the comprehensive plan and the improvements to be made in each area.

Also included in the report is a comprehensive timeline of all planned improvements to our HCBS programs. This timeline reflects our efforts to have the HCBS programs operating at greatest possible degrees of efficiency. In the next two years, we expect to have much of the burdensome paper-driven aspects of billing and care planning replaced with much more efficient electronic processes. For example, before the end of this fiscal year, we will have consolidated licensing standards for HCBS providers; implemented an electronic provider screening process; and have electronic Plans of Care in place for OAAS.

Thank you for allowing us to present information to you regarding our comprehensive plan for improving HCBS. Julia Kenny, DHH's assistant secretary for OCDD, and Hugh Eley, DHH's assistant secretary for OAAS, are available to discuss this report with you should you have any questions or comments. Please feel free to contact Julia at (225) 342-2534 or Hugh at (225) 219-0223 with any questions or comments that you may have.

Sincerely,

A handwritten signature in black ink, appearing to read "Bruce D. Greenstein". The signature is fluid and cursive, with a prominent initial "B" and a long, sweeping underline.

Bruce D. Greenstein
Secretary

Enclosures

Cc: The Honorable Members of the House Health and Welfare Committee
The Honorable Members of the Senate Health and Welfare Committee
David R. Poynter Legislative Research Library

IMPROVING HOME AND COMMUNITY BASED SERVICES

REPORT PREPARED IN RESPONSE TO ACT
299 (HB 642) OF THE 2011 REGULAR SESSION

JANUARY 2012

Contact:

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EXECUTIVE SUMMARY

Act 299 of the 2011 Regular Session builds on efforts that the Department of Health and Hospitals (DHH) has undertaken in recent years to improve the administration of home and community based services in Louisiana. The legislation requires that DHH, with the input of stakeholders, develop a comprehensive plan to include nine focus areas in order to address the delivery of quality services to individuals receiving home and community based services (HCBS) in the state.

Representatives from DHH's Office of Aging and Adult Services (OAAS) and Office for Citizens with Developmental Disabilities (OCDD) met with stakeholders and formed a task force comprised of eight subcommittees to address the issues outlined in the legislation. With the research produced by the subcommittees, DHH has developed action steps, timelines, and identified resources for the implementation of a comprehensive plan as required by Act 299. The focus areas, along with summaries of each subcommittee's findings relative to these focus areas, are listed below.

1. **Compliance-** In June, DHH published an emergency rule and notice of intent which consolidated licensing rules for all HCBS providers. Health Standards began enforcing the emergency rule in October 2011. Revisions to the rule were completed in November following extensive stakeholder input, and a final rule will be published in January 2012. The consolidated licensing rule will streamline regulations, assure provider compliance with state statutory requirements, and support the vision, values and guiding principles for Louisiana's community based long-term care services system.
2. **Accreditation-** The consolidated licensing rule will allow accredited providers to be deemed to meet licensing standards. However, requiring accreditation at this time would have a negative budgetary impact on many provider agencies and therefore result in a lack of access to services for many individuals. The task force agreed with the development of performance measures to determine if quality of care improves with accreditation. If accreditation results in improved quality of care, the provision of incentives to providers who seek accreditation is advised.
3. **Billing-** Billing procedures have been an area of needed improvement in the HCBS waivers to reduce administrative burdens for service providers. DHH is working with providers, Statistical Resources Inc., and Molina Medicaid Solutions to continually improve our active HCBS data entry system and billing process. Providers have identified several areas of needed improvement in the Louisiana Service Tracking System (LAST) software. Two of the main improvements effective October 1, 2011 allow for easier data input to the data entry section and enable providers to access reports that previously had not been available. Additionally, by September 2012, the Electronic Visit Verification (EVV) system will be in place for waiver and long term personal care services. This system will provide a highly efficient and effective way to verify that services are being received as planned and will also automate provider billing and payroll functions.
4. **Cost reporting and rate reimbursement-** Rates for the vast majority of HCBS services currently are not established based on the cost of providing the services. As a result, DHH may be over- or under-paying for many HCBS services. Absent reliable cost data, it is impossible to determine the actual facts regarding the costs of providing HCBS services. Based on research and recommendations presented by the subcommittee, the task force concurred that cost reporting should be required of HCBS providers. A draft cost report format has been completed and a rule

to require cost reporting is being prepared for publication in early 2012. Training in reporting will be available to providers in the summer of 2012. Cost reports will be due from all HCBS providers by December 2012.

5. Support coordination- Approval process and documentation requirements for support coordination are being simplified to allow individuals to begin receiving needed services more quickly. The paper driven process of Comprehensive Plans of Care will become much more efficient with the introduction of Electronic Plans of Care beginning in April 2012 and improved even further with the implementation of EVV the following September. Modifications to the approval processes for the assessment and plan of care have been developed to decrease the time and checks required for plan approval. Additionally, new monitoring processes for support coordination agencies in both OAAS and OCDD have been implemented. Training processes and core curriculums for support coordinators will be developed by June 2012.
6. Technology- Technology is being utilized to improve all aspects of HCBS. In-home technology is now an approved service in two HCBS waivers and plans for piloting an expanded use of such technology in the spring of 2012 is underway in OAAS and OCDD. A new web-based participant tracking tool was implemented by OAAS in October 2011. Web-based care planning tools are under development in both OAAS and OCDD, to be completed within the next twelve months. An on demand web-based training system and library of training to standardize and improve training in HCBS programs will be developed and implemented in 2013. Implementation of the Electronic Visit Verification (EVV) system is set for the fall of 2012 and will allow enhanced monitoring of services and improved billing and payroll functions.
7. Medicaid enrollment- DHH is in the process of completing a project with LexisNexis to improve the quality of providers enrolled under Medicaid HCBS. LexisNexis will perform a wide range of electronic verifications for Medicaid enrolled providers which will allow sweeping identification and background checks with no administrative requirements on the part of providers. Anticipated completion of the project is February 2012.
8. Medicaid delivery options- The use of Organized Health Care Delivery Systems (OHCDS) in DHH waiver programs is a promising strategy to improve HCBS service delivery and simplify administration of HCBS programs. The use of such systems could also encourage provider diversification and help build provider infrastructure for a move toward managed long term care. The subcommittee identified actions DHH would need to take in order to implement an OHCDS. By June 30, 2012, the subcommittee and DHH staff will determine the feasibility and benefits of implementation.

IMPROVING HOME AND COMMUNITY BASED SERVICES

INTRODUCTION

Louisiana has experienced a significant increase in the number of persons seeking long-term care services in home and community based programs. This is primarily caused by two factors: first, the elderly population is growing, and second, individual preference for the type of long term care delivery has been shifting from institutional settings to home and community based services (HCBS). While DHH has always strived to ensure the quality of HCBS programs, the Department recognizes that assuring quality has never been more important as the state attempts to meet the needs of a much larger and growing population.

In 2005, the Department published *Louisiana's Plan for Immediate Action: Long Term Care Choices for the Elderly and People with Disabilities*. This plan contained twelve areas of focus, including quality management and licensing, and drew upon input and feedback from a diverse group of stakeholders from across the state. This publication was followed in 2007 with *Louisiana's Plan for Choice in Long Term Care: Comprehensive Long-Term Care Reform*, which included a call for the development of a quality management system for long term care services, and the consolidation of licensing rules for all Medicaid reimbursed long term care providers.

Now, DHH is building on the progress we have made in the last few years. Act 299 requires that DHH, with input from stakeholders, develop a comprehensive plan to address the delivery of quality HCBS services. The plan must address the following specific areas of focus:

- Compliance
- Accreditation
- Billing
- Cost reporting and rate reimbursement
- Support coordination
- Technology
- Medicaid enrollment
- Medicaid delivery options

DHH staff, together with stakeholder representatives, formed eight subcommittees to address these areas of focus and have produced the following comprehensive plan. A timeline can also be found at the end of this document.

COMPLIANCE

Previously proposed action steps to improve compliance in licensing have recently come to fruition. The Comprehensive Long-Term Care Reform Plan of 2007 called for consolidation of licensing for all home and community based services into one licensing rule. Various HCBS programs had conflicting regulations that made operating and monitoring of the programs cumbersome. A workgroup was convened and has worked for the past few years to create a multi-service licensing rule that would streamline regulations, assure provider compliance with state statutory requirements, and support the vision, values and guiding principles for Louisiana's community based long-term care services system. An emergency rule for Minimum Licensing Standards for Home and Community Based Service Providers was published in the June 2011 Louisiana Register and a public hearing on the rule was held on July 27, 2011. Many comments were received as a result of the public hearing, and each of these comments is being reviewed for consideration in the final rule, slated for publication this month.

ACCREDITATION

Of the hundreds of HCBS providers in Louisiana, few have received accreditation. Provider accreditation brings with it a heightened focus on accountability and comprehensive documentation. Accreditation also allows the provider to be identified as an organization that meets internationally developed standards in delivering quality services. However, it was determined through careful consideration with stakeholders that mandatory accreditation is not advisable at this time. The fiscal impact of mandatory accreditation would be too great a burden on smaller provider agencies and would have deleterious consequences for an already overburdened HCBS provider workforce. This could result in access problems for individuals that rely on these services. Also, there are some services for which no accreditation standards exist, some accreditation standards conflict with licensing standards, and there are still questions about the extent to which accreditation actually improves the quality of services provided.

DHH remains interested in encouraging accreditation, and the accreditation subcommittee which was formed as a result of Act 299 has made two recommendations to further this goal:

1. Develop performance measures so that data can be collected on providers to determine quantitatively whether accreditation correlates to better quality of services provided. This will assist the Department in making a more informed data-driven determination on how it may be cost-effective to incentivize accreditation.
2. Explore incentives for HCBS providers to seek accreditation. This could come in the form of higher visibility on the Medicaid freedom of choice provider list, or possibly an enhanced reimbursement rate.

BILLING

Billing issues have created a significant administrative burden for HCBS providers. The cumbersome billing process begins with the provider entering detailed staff coverage information into the Louisiana Service Tracking System (LAST). The provider's information is then received by Statistical Resources Inc (SRI), who then analyzes the data and determines how much the provider may bill. The provider then has to "bridge" the data from the LAST program to their own "billing" software, and then send this to Molina to get processed.

Providers have identified several areas of needed improvement in the LAST software. Two of the main improvements which were effective October 1, 2011 are for easier data input to the data entry section and the ability of the provider to access reports that previously had not been available.

There were many changes to the data entry section for both OCDD and OAAS that allows for fewer data entry mistakes, easier automation input for providers, and the reduction of required typing for data entry. The reports of the LAST program now allow a provider to review if he has exceeded his prior authorization amount prior to billing, review weekly prior authorizations (OAAS services), and modify Service Summary Reports for a procedure code for a day. The system was updated so that changes to a Comprehensive Plan of Care (CPOC) would automatically be reflected in reported service unit counts.

Billing complexity, including the large opportunity for errors and discrepancies on multiple paper documents completed by provider staff, are major sources of audit findings and billing inefficiency. The implementation of an Electronic Visit Verification (EVV) system in September 2012, which will be discussed further in the Technology portion of this report, will greatly improve HCBS billing procedures.

RATE REIMBURSEMENT AND COST REPORTING

Rates for almost all HCBS services are not currently established based on the cost of providing the services. The sole exception is the rate for Adult Day Health Care (ADHC). Rates have been set in a variety of ways, including being mandated in settlement agreements resulting from lawsuits. Some providers feel current rates do not reflect the true costs of providing the services and in some cases are actually below costs. Absent reliable cost data, it is difficult to determine the true costs of providing HCBS services.

There have been several cuts to HCBS rates in recent years, and the various programs and services have not been cut equally. The lack of any established methodology for setting rates and the unequal application of rate cuts have led to considerable variation between rates in various HCBS programs. This is true even in cases where the service definitions are very similar and the tasks performed by workers are essentially the same. Providers who work with more than one program often note that lower paying programs (typically those that serve elders or persons with physical disabilities) are subsidized by the higher paying programs (typically those that serve persons with developmental disabilities). Many note that they could not serve the elder population at the current rates without this "subsidy" from the other programs. Some providers have stopped providing the services with lower rates. Without cost data, it is not known whether these rate differentials are justified.

Many states collect cost reports from HCBS providers and use those in cost-based rate methodologies. The neighboring state of Texas is one example. The subcommittee on cost reporting and rate reimbursement, made up of DHH staff and stakeholder representatives, reviewed cost reports used in the Texas program, those currently used by ADHC providers in Louisiana, and a detailed study on these issues conducted by Myers & Stauffer for the state of Alaska. The task force based on the recommendations of the subcommittee agreed on the following: A notice of intent to require cost reporting for HCBS providers will be published by March 31, 2012, with a final rule published by July.

- All HCBS providers will file cost reports with the state by November 30, 2012. Providers will file a single report that includes all HCBS services provided, but should file separate reports for each license number they hold. Allowable cost will be in accordance with CMS guidelines.
- To the extent possible, the cost reporting format will be the same for all HCBS services.
- Procedures will be developed for auditing of cost reports submitted by providers.
- To the extent possible, cost reports should be submitted electronically.
- Initial and ongoing training will be available for providers, using online resources where feasible.
- Reimbursement methods should be based on cost. The initial focus should be on the high volume, high expenditure services which are primarily forms of personal assistance (e.g. Personal Assistance Services, Individual and Family Support, Long Term Personal Care) and on Support Coordination. While this recommendation is the result of collaboration between DHH and stakeholder representatives, it is important to note that payment rates are ultimately dependent on appropriation of funds by the legislature.
- Reimbursement methodologies for services which are substantially identical in scope should be the same. It is expected that using the same reimbursement methodology will equalize rates at an appropriate level.
- Any adopted methodology will contain appropriate mechanisms to ensure sufficient funds go toward direct care and to promote adequate wages for direct support workers.

SUPPORT COORDINATION

Independent Support Coordination is an essential component of the service delivery system for home and community based waivers and is required as part of CMS regulations. The current processes and outcomes related to support coordination across waiver services does not currently allow for easy access to services for recipients, responsive support with minimal delays, or consistency across time for recipients.

DHH and stakeholder representatives reviewed the current support coordination delivery system and determined five areas in need of improvement. The committee then outlined an action plan with the following steps to ensure timely, efficient, and effective support coordination services for all recipients:

- Streamline approval and documentation processes. The current paper-driven Comprehensive Plan of Care (CPOC) method of approving plans of care is time-consuming and administratively burdensome for providers. This process will be improved through several initiatives, including a modified plan approval process that results in faster approval of and access to needed services; introduction of automated budget processes leading to more timely prior authorization of services; revision and streamlining of ongoing documentation requirements for annual planning and updates; and a single plan of care coordinated between the support coordinator and provider.

Streamlined plan approval processes and documentation requirements are in progress for both OCDD and OAAS, with the remaining initiatives scheduled to be implemented before the end of this fiscal year. Electronic Plans of Care will also be a great improvement to the current paper-driven approach that both OAAS and OCDD currently utilize. Electronic Plans of Care will begin in April 2012 for OAAS and January 2013 for OCDD.

- **Person Centered Thinking Tools and Systems.** OCDD has partnered with Support Development Associates (SDA), a nationally recognized consulting group to implement several activities towards becoming a more person centered service delivery system. This initiative supports ongoing streamlining efforts by ensuring that efficiencies are consistent not only with documentation streamlining but also with building community connections for recipients such that the reliance on supports provided and coordinated by the system (including the support coordinator) may decrease over time. OCDD's plan revisions have been done in consultation with SDA, and implementation of the modified planning process is occurring in conjunction with the implementation of person centered thinking tools. OCDD is in the process of having 7 staff certified to be trainers in the person centered thinking program and is partnering with two community organization and one state operated center to complete more in depth person centered organization activities.
- **Improve monitoring.** A new monitoring process for support coordination agencies is currently being utilized by both OAAS and OCDD. The Support Coordination Monitoring Tool has already been implemented by OCDD, with 50% of the enrolled HCBS agencies participating by the end of the fiscal year. OAAS implemented the process October 1st and will begin utilizing this tool statewide in January. OAAS is expecting 100% participation by December 2012. The new monitoring process is a joint effort by OCDD, OAAS, and Medicaid and is based on specific measures and outcomes rather than paper compliance.
- **Improve training.** A core curriculum will be developed by June 2012 for support coordinators. This will allow for consistent core training for all support coordination agencies, but also extend to more specialized training for assessors and supervisors, and further specialization with focus on acuity or type of condition. Enhanced training would then lead to more efficient division of labor within agencies and more effective delivery of services to participants. Additionally, implementation of joint provider and support coordination training and informational sessions will begin this fiscal year when changes or new initiatives occur.
- **Develop training and tools to improve assistance of recipient/family choice.** OCDD and OAAS will develop informational and educational tools for support coordinators to better assist recipients and families in choosing providers for all support services, including vocational options. Improved provider-recipient matches across services will lead to better and more well maintained supports and eventually better outcomes for recipients. Tools will be developed and needed training provided this fiscal year.

TECHNOLOGY

The improvement of HCBS is heavily dependent upon the effective use of technology in three vital areas: provider training, business processes, and the delivery of services to participants.

By February 2013, DHH will adopt and implement an on-line training system to ensure that providers are receiving training that is effective, consistent, and verifiable. This Learning Management System (LMS) will include the following features:

- Customized reports of course history
- Certificates validating course completion
- Ability to email users in groups or individually with specific details and updates
- Unlimited administrative accounts
- Industry standard video formats
- Text, image, multimedia and Flash content
- Automated student enrollment or manual self-enrollment
- Class size set by instructor
- Waiting list when max enrollment is met
- Certification tracking for groups of required courses
- Ability to segment courses and make visible to only certain groups of learners
- System available on a subscription basis rather than installing internally
- Ability to accept payment

With the implementation of the LMS, a library of courses will be developed that relate to populations served by OAAS, OBH, and OCDD. The primary users of these courses will be Direct Support Workers (DSW), but the subcommittee also recognizes a need to include courses that will be useful or relevant to all provider types and support coordinators at all organizational levels, including supervisors, managers, executives, owners, and directors. There will be course offerings that conform to DSW training requirements as specified in the HCBS licensing rule and in Medicaid standards for participation. Continuing Education Units (CEUs) should be provided to the maximum extent possible.

The courses included in the LMS will be available to providers for purchase through the online system. Revenue generated in this fashion should be certified for federal match and used to enhance and improve home and community based services.

The utilization of technology will also improve the business processes for both HCBS providers and for DHH. Electronic, web-based participant tracking and plan of care tools will begin in April 2012 and January 2013 for OAAS and OCDD, respectively. These systems will enhance our current HCBS business processes in the following ways:

- All parties involved in HCBS delivery will have, within their appropriate user rights, access to the same, correct, and most current information (for instance, the most current and correct plan of care);
- Electronically generated timelines and due dates will enable support coordination and provider agencies to schedule and better organize workloads;
- Aggregate and individual-level reports will allow agencies to conduct internal quality improvement;

- Support coordinators will have capacity to print plans of care and other documents in the field;
- DHH systems and field technology for support coordinators and direct support providers will evolve to include emerging mobile platforms (e.g., smart phones and tablets) and applications (HTML5, iOS, Android, Windows Phone and Windows 8) to enhance workflows and user experience in order to improve efficiency.

The Electronic Visit Verification (EVV) system for HCBS will improve monitoring of HCBS services as well as streamline billing and payroll functions for providers. This system will assure the following:

- A single system that enables not only claims transactions and tracking for state purposes of preventing fraud and abuse, but that also enables and performs provider billing and payroll functions. Industry standards suggest that there may be little to no additional costs in implementing these functionalities, and failure to do so will result in continued discrepancies between claims and paper documents (e.g. individual service logs) and other documents created and maintained by providers for purposes of payroll and billing. Billing complexity, inefficiency, and errors will continue to be an issue if the state fails to make the fullest use of EVV technology for billing, payroll, and claims.
- Worker scheduling, service delivery and quality monitoring functions of the EVV system will be available for providers to facilitate delivery of back-up services and for purposes of quality improvement.
- Provisions will be developed to accept and interface with EVV systems which providers currently have in place.

Finally, technology will be utilized to improve the delivery of services to individuals who need them and thereby improve participants' lives. OAAS and OCDD will work with technology developers to establish pilot and demonstration projects for the use of TeleHealth and TeleCare technologies with HCBS and Intermediate Care Facility (ICF) populations. Pilots should measure impact of technology on efficiency and outcomes, and demonstrations should serve to educate support coordinators and providers about the utility of technologies that can be funded through HCBS programs.

DHH will facilitate an innovations-oriented dialogue between technology developers/providers and those who provide coordination and direct care in the field. Those who provide services to program participants are aware of problems and areas for improvement, and technology developers and providers are aware of solutions and innovations that can improve programs and lives.

DHH will implement at least one HCBS technology demonstration pilot in both OAAS and OCDD by October 2012.

MEDICAID ENROLLMENT

The last few years have seen rapid growth in the number of enrolled HCBS providers in the state, often without effective assurance of capacity and effective screening to assure quality. DHH met with stakeholders to identify and recommend revisions to the provider enrollment process that support sustainable, quality HCBS programs.

DHH will conduct a thorough study and determine, by July 2012, if it is feasible to require providers to obtain a yearly independent financial audit from a certified public accountant. At the same time, a determination will be made on the necessity of a published rule for Medicaid HCBS provider enrollment.

In March of 2012, changes will be made to the provider enrollment application to allow DHH to capture more provider information, including general liability insurance and workers compensation insurance. An electronic enrollment process will be in place by December 31, 2012.

DHH is also in the process of completing a project with LexisNexis to improve the quality of providers enrolled under Medicaid HCBS. Through a comprehensive network of online databases, DHH will have the ability to conduct detailed analysis of enrolled providers in a variety of ways including: national and state licensure and sanction checks; verification of good standing with Secretary of State; extensive identity verification and criminal background checks; verification of ownership, specialty certification, group practice and hospital affiliations; and history of bankruptcies, liens and judgments checks. This project will be completed by February 2012.

MEDICAID DELIVERY OPTIONS

In developing a comprehensive plan to improve the quality of services provided to individuals receiving home and community based services, the subcommittee researched and discussed the use of Organized Health Care Delivery Systems (OHCDS) as an option for the provision of Medicaid-funded home and community based services.

In order to be an OHCDS, a provider must be enrolled in and provide at least one Medicaid funded health care service to its consumers directly through its own employees. The OHCDS designation allows the entity to contract and bill on behalf of individual providers for the payment of other Medicaid payable services if the subsumed providers have a contract with the OHCDS providing for the billing arrangement.

OHCDS providers may reimburse other service providers with whom it has a contract with at a rate equal to or less than the approved Medicaid rate for the service to be delivered. The OHCDS is responsible for processing claims, maintenance of documentation, and the verification of the credentials of the providers with whom it subcontracts. The sub-contracted providers do not have to be enrolled in Medicaid. The OHCDS provider is also responsible for ensuring the subcontracted service is delivered in accordance with the plan of care, the individual cost plan, and the applicable qualified provider standards for the service. The OHCDS provider is also responsible for the establishment and maintenance of a funding and service delivery paper trail, enabling auditors to verify the delivery of services in accordance with funding.

No qualified provider can be required to subcontract with an OHCDS, and no consumer may be denied choice of provider by an OHCDS.

Based on the subcommittee's initial findings, further research is recommended to assess whether the Office for Citizens with Developmental Disabilities (OCDD) could be used as an OHCDS. Such an arrangement also has the potential to allow better coordination of care, particularly for consumers with multiple complex needs, because the OHCDS is not limited to delivering services solely through Medicaid enrolled providers.

Additionally, the OHCDS concept could also be beneficial as a part of the service delivery model for Louisiana's statewide early intervention system, EarlySteps, which serves children aged 0-3. Significant input would be required from OCDD, which is also the Lead Agency for Early Steps. However, it is possible that the OHCDS model could be used as a tool to address systemic issues including providing better access for underserved and rural populations, appropriate service utilization, and implementation of best practices in service delivery. The provider enrollment process could be shortened and simplified as individual providers would not have to enroll with Medicaid; the billing process would also be simplified for these providers. These factors are likely to result in a larger pool of potential providers. The additional potential benefit of the OHCDS model is that the provider entity responsible for contracting with or employing early intervention providers could also provide training and oversight to ensure regulatory compliance, appropriate service delivery, and accountability.

The OHCDS could also be used to address similar problems posed for programs serving other populations, such as the elderly and persons with adult-onset disabilities. For example, the wide array of services now offered by OAAS through the Community Choices Waiver includes many services not traditionally provided by waiver providers. The use of the OHCDS model could encourage providers of these new services to participate in the waiver by enabling them to provide multiple services with less administrative burden. It also would potentially simplify the receipt of services by participants by allowing them to choose a single provider through which multiple services could be obtained.

Should the state decide to use an OHCDS in Louisiana, the following actions would have to be taken:

- Develop amendments to the waiver application/state plan;
- Request approval of the amendments from the federal oversight agency;
- Amend any applicable waiver or state plan rules/policies/procedures to provide for use of OHCDS;
- Develop enrollment packets/contracts for providers to enroll as an OHCDS;
- Make necessary changes to programming to provide for payment of OHCDS; and
- Offer recipients the option to use this type of provider.

Improving HCBS: Comprehensive Timeline

2011

June

HCBS Minimum Licensing Standards published as an Emergency Rule and Notice of Intent (6/20)

July

Emergency Rule and Notice of Intent for Minimum Licensing Standards becomes effective (7/1)

Public Hearing regarding Emergency Rule and Notice of Intent for Minimum Licensing Standards (7/27)

October

Automation of OAAS budget process

Implementation of streamlined approval process for OAAS

Simplified approval process for Children's Choice waiver submitted to CMS (implementation to begin within 30 days of approval)

Health Standards begins enforcing the Minimum Licensing Standards Emergency Rule (10/1)

Implementation of OCDD Support Coordination Monitoring Tool and Process

November

Establish workgroup for development of support coordination training core curriculum

December

All improvements to LAST system to be implemented (12/1)

Initial draft cost report format complete (12/31)

Simplified approval process for NOW/Supports Waiver submitted to CMS (implementation to begin within 30 days of approval)

Specialization areas for support coordinators defined for OCDD

Complete review of licensing requirements for provider plan of care

Provider screening contract with LexisNexis secured (by 12/31)

2012

January

Publication of Final Rule for HCBS Minimum Licensing Standards

Automation of OCDD budget process complete

Implementation of OAAS Support Coordination Monitoring Tool and Process

Implementation of specialization areas for support coordinators in OCDD

Begin OCDD support coordinator provider training for flexible hours usage

Review support coordinator turnover protocols with support coordination alliance

Complete modifications to Support Plan

March

Notice of Intent for Cost Reporting published (3/31)

Provider training in place for cost reporting procedures (3/31)

April

Completion of Participant Tracking and Electronic Plan of Care for OAAS

May

Training held for providers on cost reporting process

June

Completion of OAAS electronic plan of care

Development of content areas and curriculum for support coordination training complete

Assess options for automated/electronic training offerings

Complete review of support coordination documentation processes and determine options for streamlining

Assess viability of provider report card system and present recommendations to OCDD and OAAS leadership

Develop tools and informational handouts for recipients and families regarding support coordination provider choice

July

Cost Reports Rule effective for Fiscal year 2013 (7/1)

Implementation of support coordination training core curriculum

August

Complete implementation of web-based field technology for support coordination agencies

September

Implement Electronic Visit Verification system for waiver and Long Term Personal Care Services

November

Initial cost reports due from HCBS providers, cost report auditing begins (11/30)

October

OCDD and OAAS each will have implemented at least one HCBS technology demonstration project

2013

January

Completion of Participant Tracking and Electronic Plan of Care for OCDD

February

Learning Management System (LMS) available

Library for direct service workers licensing available through LMS

CONCLUSION

Home and community based services are vital for thousands of people in Louisiana. DHH is committed to an ongoing process of quality improvement to make these programs and services more effective and more efficient. Such an effort is critical to ensuring the sustainability of these services in the face of growing demand.

Implementation of the initiatives detailed in this report will mark a huge step forward in improving the quality of home and community based services provided in the state. The focus of DHH is to continually improve quality of services and effectiveness for participants, to use available resources wisely to serve as many persons as possible, and to guard against fraud or billing errors. Each of the planned initiatives outlined in this report have this focus in mind. New technology systems, like the Electronic Plans of Care and the Electronic Visit Verification System, will mean services that are accessed more effectively, planned and delivered more efficiently, and more closely monitored, resulting in better experiences and better outcomes on the part of participants. Improved training through the development of a consistent core curriculum for support coordinators and an electronic Learning Management System for direct service workers will result directly in more consistent, higher quality services to individuals who rely on these workers for their care.

More efficient administrative procedures, such as electronic provider screening, will allow better monitoring of providers to ensure ongoing compliance, and will also allow providers to focus more on delivering quality services than on complicated documentation requirements. Lastly, a reimbursement methodology that is consistent, fair, and evidence-based will ensure that participants continue to have access to quality services in the future.

The implementation of the initiatives and action steps outlined in this report will ensure that persons receiving home and community based services in the state receive the most effective, quality care at a lower cost.

Acknowledgments

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Regular Session, 2011

ACT No. 299

HOUSE BILL NO. 642 (Substitute for House Bill No. 440 by Representative Burford)

BY REPRESENTATIVES BURFORD, ARMES, HENRY BURNS, CHANDLER, CHANEY, GISCLAIR, HAZEL, HOFFMANN, HOWARD, MONTOUCET, NOWLIN, PUGH, GARY SMITH, JANE SMITH, TUCKER, WILLMOTT, AND WOOTON

AN ACT

To amend and reenact R.S. 37:1031(A)(introductory paragraph) and (D), 1033(A)(3) and (4), (B), (D)(1), (F), and (H), and 1034(3) and R.S. 40:2120.4(B)(1), 2120.5(D), and 2179(C), to enact R.S. 37:1031(A)(5) and (E) and R.S. 40:2119, and to repeal R.S. 37:1033(G), relative to home- and community-based providers; to provide for the applicability of statutory provisions governing direct service workers; to provide for appropriate training of direct service workers; to provide for the termination of authorization of direct service workers to perform certain procedures; to require the department to develop a comprehensive plan regarding the quality of services provided to individuals receiving home- and community-based services; to provide for licensure procedures and requirements applicable to granting deemed status to home- and community-based providers; to extend the application of state laws governing direct service workers to all direct service workers regardless of the type of compensation; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 37:1031(A)(introductory paragraph) and (D), 1033(A)(3) and (4), (B), (D)(1), (F), and (H), and 1034(3) are hereby amended and reenacted and R.S. 37:1031(A)(5) and (E) are hereby enacted to read as follows:

§1031. Applicability

A. The provisions of this Part shall not apply to gratuitous care provided by friends or members of the individual's family. The provisions of this Part shall apply to all direct service workers employed by a licensed agency, or employed as part of an authorized departmental self-directed program, and who attend to individuals

1 receiving ~~state or federally funded home~~ home- and community-based long-term
2 services and who are not authorized to perform these tasks under other state laws or
3 regulations. An individual being served shall meet the following criteria:

4 * * *

5 (5) Requires assistance with medication administration or other noncomplex
6 medical tasks.

7 * * *

8 D. A registered nurse may delegate to a licensed practical nurse components
9 of the training and supervision of the direct service worker provided that the
10 registered nurse shall retain the responsibility and accountability for all acts of
11 delegation and ensuring authorization and competency validation.

12 ~~D:~~ E. The Department of Health and Hospitals, in conjunction with the
13 Louisiana State Board of Nursing, shall promulgate rules and regulations necessary
14 to enable the implementation of this Part, and other rules and regulations concerning
15 direct service workers consistent with this Part.

16 * * *

17 §1033. Required training; ~~registration~~

18 A. In order to be authorized to perform the procedures specified in R.S.
19 37:1032, a direct service worker shall be employed by a licensed agency or
20 employed as part of an authorized departmental self-directed program and shall
21 receive the following training:

22 * * *

23 (3) In order to administer noncomplex tasks, complete didactic training, and
24 demonstration of competency in accordance with guidelines established and
25 approved by the Department of Health and Hospitals and the Louisiana Board of
26 Nursing.

27 ~~(3)~~ (4) ~~At least six hours of~~ Appropriate person-specific training from a
28 registered nurse who has assessed the health status of the individual ~~in the residence~~
29 ~~where the receiving services are to be performed~~ and determined that the direct
30 service worker can perform the tasks in a safe, appropriate manner, with additional

1 person-specific training by a registered nurse whenever the tasks to be performed or
 2 the types of medications to be administered are changed. Written documentation of
 3 training provided by the registered nurse shall be submitted to and maintained by the
 4 direct service worker's ~~employing agency~~ employer.

5 ~~(4) Current Cardio-Pulmonary Resuscitation certification:~~

6 B. Any unlicensed person performing the procedures authorized by this Part
 7 shall complete the training required by this Section no later than ~~thirty-six~~ twelve
 8 months after promulgation of the regulations required by this Part. Training
 9 specified in Subsection A of this Section shall be repeated if the registered nurse
 10 does not certify that the direct service worker has demonstrated a sufficient level of
 11 competency in the subject matter.

12 * * *

13 D.(1) Any ~~registered~~ licensed nurse who has properly trained and
 14 documented that a direct service worker can perform the prescribed tasks shall not
 15 be liable for any civil damages as a result of any act or omission of the direct service
 16 worker.

17 * * *

18 F. Direct service workers performing with a finding on the Department of
 19 Health and Hospital's Direct Service Worker Registry shall not perform tasks under
 20 pursuant to this Part, ~~shall maintain current registration with the Department of~~
 21 ~~Health and Hospital's Direct Service Worker Registry.~~

22 * * *

23 H. ~~During the thirty-six month training period required by Subsection B of~~
 24 ~~this Section, the~~ The Department of Health and Hospitals and the Louisiana State
 25 Board of Nursing shall meet ~~quarterly~~ at least annually to review data collected by
 26 the Department of Health and Hospitals that is relevant to the administration of
 27 health care tasks authorized by this Part. The Department of Health and Hospitals
 28 and the Louisiana State Board of Nursing shall use the data to evaluate the efficiency
 29 of this program and shall make joint recommendations to the secretary of the

1 Department of Health and Hospitals and the executive director of the Louisiana State
2 Board of Nursing for any needed revisions.

3 §1034. Termination of authorization

4 Authorization for a direct service worker to perform any of the tasks specified
5 in R.S. 37:1032 shall be terminated for any of the following reasons:

6 * * *

7 (3) The direct service worker ~~no longer maintains current registration in~~ has
8 a finding against him placed on the Direct Service Worker Registry.

9 * * *

10 Section 2. R.S. 40:2120.4(B)(1), 2120.5(D), and 2179(C) are hereby amended and
11 reenacted and R.S. 40:2119 is hereby enacted to read as follows:

12 §2119. Comprehensive plan

13 A. The Department of Health and Hospitals is hereby directed to develop a
14 comprehensive plan to address the delivery of quality services to a person receiving
15 home- and community-based services, and the department shall submit a written
16 report to the House Committee on Health and Welfare and the Senate Committee on
17 Health and Welfare by January 15, 2012.

18 B. The plan shall be developed with input from stakeholders and shall
19 include action steps, recommended time lines, and identified necessary resources for
20 implementation, and shall address the following:

21 (1) Accreditation - accreditation of home- and community-based service
22 providers.

23 (2) Compliance - assurance that all home- and community-based service
24 providers meet the standards for licensure and plan for monitoring to ensure ongoing
25 compliance.

26 (3) Billing - appropriate revisions to streamline the procedures for the billing
27 of home- and community-based services and the monitoring thereof to reduce fraud
28 and errors.

1 either obtain accreditation through a recognized national, not-for-profit accrediting
 2 body approved by the department, or comply with any other procedure developed by
 3 the department to ensure that every home- and community-based provider meets
 4 minimum standards for the delivery of services and is in compliance with all
 5 applicable federal and state regulations; the licensure procedures and requirements
 6 may include provisions for denying and revoking deemed status, for complaint
 7 surveys and investigations of providers holding deemed status, and for approved
 8 accreditation organizations. Deemed status shall not be available to persons or
 9 entities seeking initial licensure with the department.

* * *

11 §2120.5. License issuance; application; onsite inspection

* * *

13 D. As a condition for a renewal of a license, the licensee ~~must~~ shall submit
 14 to the licensing agency a completed annual renewal application on forms prescribed
 15 by the licensing agency and ~~shall contain~~ containing such information as required by
 16 the agency; additionally, the annual renewal licensing fee ~~must~~ shall be submitted
 17 with the annual renewal application. Upon receipt of the completed annual renewal
 18 application and the annual renewal licensing fee, the licensing agency shall
 19 determine if the facility or provider continues to meet the requirements established
 20 ~~under pursuant to~~ this Part and the licensing standards adopted pursuant to this Part.
 21 The licensing agency may perform an onsite survey and inspection upon annual
 22 renewal. If the facility or provider continues to meet the requirements established
 23 ~~under pursuant to~~ this Part and the licensing standards adopted pursuant to this Part,
 24 a license shall be issued which is valid for one year.

* * *

26 §2179. Establishment of Direct Service Worker Registry

* * *

28 C. The provisions of this Part shall apply ~~only~~ to direct service workers who
 29 are compensated ~~through state or federal funds~~, regardless of the setting, and
 30 specifically do not apply to those direct service workers listed on the Certified Nurse

1 Aide Registry established under rules promulgated by the Department of Health and
2 Hospitals.

3 * * *

4 Section 3. R.S. 37:1033(G) is hereby repealed in its entirety.

SPEAKER OF THE HOUSE OF REPRESENTATIVES

PRESIDENT OF THE SENATE

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____