

**RULE**

**Department of Health and Hospitals  
Bureau of Health Services Financing**

**Administrative Procedures  
Tribal Consultation Process  
(LAC 50:I.105)**

The Department of Health and Hospitals, Bureau of Health Services Financing has adopted LAC 50:I.105 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 I. Administration  
Subpart 1. General Provisions**

**Chapter 1. Administrative Procedures**

**§105. Tribal Consultation Process**

A. Pursuant to §1902(a)(73) and §2107(e)(I) of the Social Security Act, the Medicaid Program hereby establishes a process to seek advice on a regular, ongoing basis from designees of the state's federally-recognized Indian tribal organizations and Indian health programs about Medicaid and Children's Health Insurance Program matters that may have a direct impact on Indian health programs and tribal organizations.

B. The department shall comply with the technical requirements for providing verification of the tribal consultation

process to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) when changes to the Medicaid Program are submitted through:

1. State Plan amendments;
2. waivers, including:
  - a. newly proposed submissions;
  - b. amendments;
  - c. extensions;
  - c. renewals; and
  - d. waiver terminations.

C. In accordance with the approved Medicaid State Plan governing the tribal consultation process, the Medicaid Program will periodically provide a summary, which includes the changes being made by the Medicaid Program, to the federally-recognized Louisiana tribal organizations to initiate the tribal consultation process.

1. Tribal organizations will have 30 days to respond with any comments, unless the date for submission of the changes to CMS becomes critical and needs to be expedited. Expedited submissions will have a 7-day comment period. This notification and comment period applies to all State Plan and waiver submissions.

2. If comments are received, they will be forwarded to the State Medicaid Director, or his/her designee, for further consideration. If no comments are received within the 30- or 7-day time frame, the Medicaid Program will make the assumption the tribes

agree with the provisions in the proposed State Plan and waiver documents and proceed accordingly.

D. The tribal comment period must expire prior to the submission of State Plan and waiver documents to CMS.

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, LR 42:

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.

Rebekah E. Gee MD, MPH

Secretary

**RULE**

**Department of Health and Hospitals  
Bureau of Health Services Financing**

**Direct Service Worker Registry  
(LAC 48:I.Chapter 92)**

The Department of Health and Hospitals, Bureau of Health Services Financing have amended LAC 48:I.Chapter 92 as authorized by R.S. 37:1031-1034 and R.S. 40:2179-2179.1. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

**Title 48**

**PUBLIC HEALTH-GENERAL  
Part I. General Administration  
Subpart 3. Health Standards**

**Chapter 92. Direct Service Worker Registry**

**Subchapter A. General Provisions**

**§9201. Definitions**

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*Activities of Daily Living (ADLs)*—the functions or tasks which are performed by an individual in a typical day, either independently or with supervision/assistance. Activities of daily living may include, but are not limited to, bathing, dressing, eating, grooming, walking, transferring and/or toileting.

*Assistance with Activities of Daily Living*—services that provide assistance with activities of daily living. Such assistance may be the actual performance of the task for the

individual, or may provide hands-on assistance with the performance of the tasks, or may include supervision and prompting to allow the individual to self-perform such tasks.

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*DAL*—Division of Administrative Law or its successor.

*Department*—the Louisiana Department of Health and Hospitals (DHH).

*Direct Service Worker (DSW)*—an unlicensed person who provides personal care or other services and support to persons with disabilities or to the elderly to enhance their well-being, and who is involved in face-to-face direct contact with the person. Functions performed may include, but are not limited to, assistance and training in activities of daily living, personal care services, and job-related supports. Examples of direct service workers employed or contracted in a licensed and/or certified health care setting include, but are not limited to:

1. patient care technicians;
2. hospital aides;
3. unlicensed assistive personnel (UAPs);
4. home health aides;
5. hospice aides;
6. direct care workers;
7. mental health technicians;
8. mental health aides;

9. mental health orderlies;
10. nursing aides or hospital orderlies;
11. nursing assistants;
12. patient care aides; and/or
13. any persons hired as unlicensed direct care staff

that meet the provisions of this chapter.

Note: Those persons who are listed on the Certified Nurse Aide Registry and who are employed as certified nurse aides in a licensed and/or certified nursing facility and/or a skilled nursing facility within a hospital are not included under these provisions as a direct service worker.

*Disability*-a physical or mental impairment which substantially limits one or more of the major life activities of an individual or who has a history of such impairment or who is regarded as having such impairment; having a condition (such as an illness or an injury) that damages or limits a person's physical or mental abilities, either temporarily or on a permanent basis.

*Elderly*-any adult over 75 years old or individuals over 65 years old who have functional impairments.

*Employed*-performance of a job or task for compensation, such as wages or a salary. An employed person may be one who is contracted or one who is directly hired for an on staff position.

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*Exploitation*—the illegal or improper use or management of the funds, assets or property of an adult with disabilities or who is elderly, or the use of the power-of-attorney or guardianship of an adult with disabilities or who is elderly for one's own profit or advantage.

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*Finding*—allegations of abuse, neglect, exploitation or extortion that are placed on the registry by the department for the following reasons:

1. after a final decision by an administrative law judge or a court of law, after all appeal delays afforded by law are exhausted; or
2. failure by the accused to timely request an appeal in accordance with the provisions of this Rule.

*Health Care Provider*—any health care facility, agency, or entity licensed and/or certified by DHH. Such entities may be referred to in other laws, statutes and regulations as providers, agencies, clinics, residential care units, homes or facilities. Health care providers include, but are not limited to, the following:

1. nursing facilities;
2. hospice providers;
3. hospitals;

4. intermediate care facilities;
5. adult residential care providers;
6. adult day health care centers;
7. home health agencies;
8. behavioral health providers;
9. dialysis units; or
10. home and community based services providers.

*Health Standards Section (HSS)*—the section of the Department of Health and Hospitals responsible for the licensing and/or certification of health care providers.

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*Independent Living Environment*—Repealed.

*Major life activities*—functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.

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*Person-Specific Training*—a set of knowledge, skills, training and abilities that address the client's strengths, restrictions relative to aging, disabilities, health care needs and related factors in order to meet the unique needs of the person receiving care.

*Plan of Care*—a plan that describes the assistance or services required to be provided to a person receiving home and community-based services, as defined herein. The plan also



describes who shall provide the assistance and the frequency and/or duration of the services that shall be provided.

*Provider—*

1. an entity that furnishes care and services to consumers and has been licensed and/or certified by the department to operate in the state;

2. in the case of an authorized departmental self-directed program, provider shall be the entity or individual as specified by the program employing or contracting the direct service worker.

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AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2179-2179.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2058 (November 2006), amended LR 33:95 (January 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3175 (December 2012), LR 42:

**§9202. Introduction**

A. The Department of Health and Hospitals (DHH) shall maintain a registry of individuals for whom specific findings of abuse, neglect, exploitation or extortion have been

substantiated by the department, an administrative law judge, or a court of law.

B. - B.6. ...

C. Licensed and/or certified health care providers shall access the registry to determine if there is a finding that a prospective hire or currently employed or contracted direct service worker has been determined to have committed abuse or neglect of an individual being supported, or misappropriated the individual's property or funds. If there is such a finding on the registry, the prospective employee shall not be hired nor shall a current employee have continued employment with the licensed and/or certified health care provider.

D. All provisions of this Chapter, except Subchapter D, §9241-§9261, Medication Administration and Noncomplex Tasks in Home and Community-Based Settings, applies to any licensed and/or certified health care provider who employs or contracts direct service workers who provide personal care or other services and support to persons with disabilities or to the elderly to enhance their well-being, and who is involved in face-to-face direct contact with the person.

1. Exception. Home and community-based services providers are required to meet all provisions of this Chapter, inclusive of Subchapter D, §9241-§9261, if the HCBS provider employs or contracts direct service workers who perform

medication administration and noncomplex medical tasks in the HCBS setting.

E. The provisions of this Chapter shall apply to direct service workers who are compensated, regardless of the setting, and specifically do not apply to those direct service workers listed on the Certified Nurse Aide Registry established under rules promulgated by the Department of Health and Hospitals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2179-2179.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2059 (November 2006), amended LR 33:95 (January 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3176 (December 2012), LR 42:

### **Subchapter C. Provider Participation**

#### **§9231. Health Care Provider Responsibilities**

A. Prior to hiring any direct service worker or trainee, the licensed and/or certified health care provider shall:

1. assure that the individual is at least 18 years of age, and that they have the ability to read, write and comprehend the English language; and
2. access the registry in accordance with the provisions of §9202.C.

B. The health care provider shall have a written process to check the registry every six months to determine if any currently employed or contracted direct service worker or trainee has been placed on the registry with a finding that he/she has been determined to have committed abuse or neglect of an individual being supported or misappropriated the individual's property or funds.

1. The provider shall follow the agency's process in demonstration of compliance with this procedure.

2. If there is such a finding on the registry, the employee shall not have continued employment with the licensed and/or certified health care provider in accordance with the provisions of §9202.C.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2179-2179.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2061 (November 2006), amended LR 33:97 (January 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3176 (December 2012), LR 42:

**Subchapter D. Medication Administration and Noncomplex Tasks in Home and Community-Based Settings**

**§9243. General Requirements for the Performance of Medication Administration and Noncomplex Tasks in Home and Community-Based Settings**

A. ...

1. be employed or contracted by an agency licensed and/or certified by the HSS or employed as part of an authorized departmental self-directed program; and

A2. - B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1031-1034.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3177 (December 2012), amended LR 42:

**§9245. Training Requirements for the Performance of Medication Administration and Noncomplex Tasks in Home and Community-Based Settings**

A. - C. ...

D. Any direct service worker currently employed or contracted to perform the procedures authorized by this Chapter shall complete the training required by this Subchapter no later than 12 months after promulgation of this Rule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1031-1034.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3177 (December 2012), amended LR 42:

**§9253. Registered Nurse Responsibilities**

A. - A.6. ...

7. completing and submitting the required documentation to the licensed and/or certified agency employing or contracting the direct service worker.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1031-1034.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3178 (December 2012), amended LR 42:

**§9257. Liability**

A. ...

B. Any physician licensed to practice medicine by the Louisiana State Board of Medical Examiners, whether or not the physician developed the person's plan of care, including but not limited to the prescribed medical regime, who is rendering professional medical care services shall not be liable for any civil damages as a result of any negligent or intentional act or omission of the direct service worker or licensed and/or certified agency.

C. Notwithstanding any other provision of law, licensed and/or certified agencies that employ or contract direct service workers shall be liable for acts or omissions of the direct service worker.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1031-1034.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3179 (December 2012), amended LR 42:

**§9261. Violations and Noncompliance**

A. ...

B. In accordance with §9259.A(2), authorization for a direct service worker to perform any of the tasks specified in R.S. 37:1032 shall be terminated if the registered nurse certifies that the direct service worker can no longer perform the prescribed tasks safely and the direct service worker shall immediately cease performing such procedures.

C. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1031-1034.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3180 (December 2012), amended LR 42:

**Subchapter E. Violations**

**§9273. Allegations of Direct Service Worker Wrong-Doing**

A. The department, through the Division of Administrative Law, or its successor, provides a process for the review, investigation, and appeal of all allegations of wrong-doing by direct service workers. Direct service workers and trainees shall not:

1. - 2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2179-2179.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2061 (November 2006), amended LR 33:98 (January 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3180 (December 2012), LR 42:

**§9275. Notice of Violation**

A. When there are substantiated allegations against the direct service worker, either through oral or written evidence, the department will notify the individual(s) implicated in the investigation of the following:

1. - 2. ...

3. the right to request from HSS an informal discussion (informal dispute resolution process); and



4. the right to request from the Division of Administrative Law an administrative hearing (appeal).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2179-2179.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2061 (November 2006), amended LR 33:98 (January 2007), LR 42:

**§9277. Informal Dispute Resolution**

A. When a direct service worker feels that he/she has been wrongly accused, the following procedure shall be followed:

1. The direct service worker may request an informal dispute resolution (IDR) within 15 calendar days of the receipt of the department's notice of violation. The request for an IDR shall be made to the HSS in writing.

2. The IDR is designed:

a. to provide an opportunity for the direct service worker to informally discuss the allegations that make the basis for placement of the finding;

b. - c. ...

3. An IDR session will be arranged within 20 days of receipt of the written request.

4. During the IDR, the direct service worker will be afforded the opportunity to:

a. talk with agency personnel assigned to the  
IDR;

b. - e. ...

5. Notice of the results of the IDR decision will be forwarded to the DSW in writing. Such written notice will include any further opportunities for appeal, if necessary and/or appropriate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2179-2179.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2061 (November 2006), amended LR 33:98 (January 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3180 (December 2012), LR 42:

## **Subchapter F. Administrative Hearings**

### **§9285. General Provisions**

A. ...

1. The request for an administrative hearing shall be made in writing to the Division of Administrative Law, or its successor.

2. The request shall contain a statement setting forth the specific allegations which the direct service worker disputes and the reasons for this dispute.

A.3. - B. ...

B.1. - B.1.c. Repealed.

C. The administrative hearing shall be conducted by an administrative law judge from the Division of Administrative Law, or its successor, as authorized by R.S. 46:107 and according to the Administrative Procedure Act.

1. - 9. Repealed.

D. If there is a final and binding administrative hearing decision to place a finding on the DSW Registry against the direct service worker, the department shall place the direct service worker's name and the adverse findings on the DSW Registry. The occurrence and findings will remain on the DSW Registry permanently.

D.1. - H. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2179-2179.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2062 (November 2006), amended LR 33:98 (January 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3180 (December 2012), LR 42:

**§9287. Preliminary Conferences**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S.  
40:2179-2179.1.

HISTORICAL NOTE: Promulgated by the Department of Health  
and Hospitals, Office of the Secretary, Bureau of Health  
Services Financing, LR 32:2062 (November 2006), amended LR 33:99  
(January 2007), amended by the Department of Health and  
Hospitals, Bureau of Health Services Financing, LR 38:3180  
(December 2012), repealed LR 42:

**§9293. Failure to Appear at Administrative Hearings**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S.  
40:2179-2179.1.

HISTORICAL NOTE: Promulgated by the Department of Health  
and Hospitals, Office of the Secretary, Bureau of Health  
Services Financing, LR 32:2063 (November 2006), amended LR  
33:100 (January 2007), amended by the Department of Health and  
Hospitals, Bureau of Health Services Financing, LR 38:3181  
(December 2012), repealed LR:42

Rebekah E. Gee MD, MPH

Secretary

**RULE**

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

**Home and Community-Based Services Waivers  
Children's Choice Waiver  
Unit of Reimbursement  
(LAC 50:XXI.12101)**

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:XXI.12101 under 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 9. Children's Choice**

**Chapter 121. Reimbursement**

**§12101. Unit of Reimbursement**

A. ...

B. Direct service providers shall be reimbursed according to the following unit of reimbursement approach. Actual rates will be published in the Children's Choice Waiver provider manual, and will be subsequently amended by direct notification to the affected

providers. For services provided by a subcontractor agency, the enrolled direct service provider shall coordinate and reimburse the subcontractor according to the terms of the contract and retain the administrative costs.

1. Family support, crisis support, center-based respite, aquatic therapy, art therapy, music therapy, sensory integration and hippotherapy/therapeutic horseback riding services shall be reimbursed at a flat rate per 15-minute unit of service and reimbursement shall not be made for less than 15-minute (one quarter-hour) of service. This covers both service provision and administrative costs.

a. Up to two participants may choose to share family support services if they share a common provider of this service.

b. Up to two participants may choose to share crisis support services if they share a common provider of this service.

c. There is a separate reimbursement rate when these services are shared.

2. - 3. ...

4. Direct Support Professionals Wages

a. The minimum hourly rate paid to providers for full-time equivalent (FTE) direct support professionals shall be the federal minimum wage in effect at the time.

B.4.b. - D.1.c. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1987 (September 2002), LR 33:1872 (September 2007), amended by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 34:250 (February 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 36:324 (February 2010), LR 36:2280 (October 2010), LR 37:2157 (July 2011), LR 39:2504 (September 2013), LR 40:68 (January 2014), LR 41:128 (January 2015), LR 42:

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.

Rebekah E. Gee MD, MPH

Secretary

**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  
Unit of Reimbursement  
(LAC 50:XXI.9501)**

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services have amended LAC 50:XXI.9501 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 7. Community Choices Waiver**

**Chapter 95. Reimbursement**

**§9501. Unit of Reimbursement**

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, and reimbursement shall not be made for less than one quarter hour (15 minutes) of service:



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

a. up to three participants may share personal assistance services if they live together and share a common provider of these services; and

b. there is a separate reimbursement rate for shared personal care services.

c. Repealed.

A.2.-B.3. ...

4. transition expenses (not to exceed the maximum lifetime limit set by OAAS); and

B.5. - E. ...

F. The following services shall be reimbursed on a per-visit basis:

1. certain nursing and skilled maintenance therapy procedures; and

2. personal assistance services furnished via "a.m. and p.m." delivery method.

G. The following services shall be reimbursed on a per-visit basis:

1. certain environmental accessibility adaptations; and

2. certain nursing, and skilled maintenance therapy procedures.

H. ...

I. - L.1. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3525 (December 2011), amended LR 39:322 (February 2013), LR 39:508 (March 2013), repromulgated LR 39:1048 (April 2013), amended LR 39:1779 (July 2013), LR 40:793 (April 2014), LR 42:

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.

Rebekah E. Gee MD, MPH

Secretary

**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  
Unit of Reimbursement  
(LAC 50:XXI.14301)**

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:XXI.14301 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 143. Reimbursement**

**§14301. Reimbursement Methodology**

**Chapter 143. Reimbursement**

**§14301. Unit of Reimbursement**

A. Reimbursement for 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 and reimbursement shall not be made for less than 15

minutes (one quarter hour) of service. This covers both service provision and administrative costs for the following services:

1. ...

2. community integration development:

a. up to three participants may choose to share community integration development if they share a common provider of this service;

b. there is a separate reimbursement rate for community integration development when these services are shared;

3. - 4. ...

5. individualized and family support-day and night:

a. up to three participants may choose to share individualized and family support services if they share a common provider;

b. there is a separate reimbursement rate for individualized and family support when these services are shared;

6. ...

7. skilled nursing services:

a. up to three participants may choose to share skilled nursing services if they share a common provider;

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

c. ...

d. - e. Repealed.

A.8. - E. ...

F. Remote assistance is paid through an hourly rate.

1. - 10.d. Repealed

G. Direct Support Professionals Wages. The rate paid to direct support professionals shall be the federal minimum wage in effect at the time.

G.1. - L. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1209 (June 2004), amended by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 34:252 (February 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 35:1851 (September 2009), amended LR 36:1247 (June 2010), LR 37:2158 (July 2011), LR 39:1049 (April 2013), LR 40:80 (January 2014), LR 42:

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.

Rebekah E. Gee MD, MPH

Secretary

**RULE**

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

**Home and Community-Based Services Waivers  
Rate Methodology  
(LAC 50:XXI.Chapter 7)**

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services have amended LAC 50:XXI.701 and adopted §703 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 1. General Provisions**

**Chapter 7. Reimbursement Methodology**

**§701. Cost Reporting Requirements**

A. Effective July 1, 2012, the department shall implement mandatory cost reporting requirements for providers of home and community-based waiver services who provide personal care services (including personal care services, personal care attendant services, community living supports services, attendant care services, personal assistance services, in-home respite, and individual and family support services). The cost

reports will be used to verify expenditures and to support rate setting for the services rendered to waiver recipients.

B. - C. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:509 (March 2013), amended LR 42:

**§703. Rate Methodology**

A. Reimbursement for the following services shall be a prospective flat rate for each approved unit of service that is provided to the recipient:

1. personal care services;
2. personal care attendant services;
3. community living supports services;
4. attendant care services;
5. personal assistance services;
6. in-home respite; and
7. individual and family support services,

collectively referred to as reimbursable assistance services.

B. One quarter hour (15 minutes) shall be the standard unit of service. Reimbursement shall not be paid for the provision of less than one quarter hour (15 minutes) of service.



C. Effective July 1, 2016, a rate validation process will occur to determine the sufficiency of reimbursement rates. This process will be repeated at a minimum of every two years thereafter. The rate validation process will involve the comparison of current provider reimbursement rates to reimbursement rates established using the department's reimbursement methodology.

1. The department's reimbursement methodology will establish an estimated reimbursement rate through the summation of the following two rate component totals:

- a. adjusted staff cost rate component; and
- b. other operational cost rate component.

2. The adjusted staff cost rate component will be determined in the following manner:

a. Direct service worker wage expense, contract labor expense, and hours worked for reimbursable assistance services will be collected from provider cost reports.

i. Collected wage and contract labor expense will be divided by collected hours worked, on an individual cost report basis, to determine a per hour labor rate for direct service workers.

ii. The individual cost report hourly labor rates will be aggregated for all applicable filed cost reports,

outliers will be removed, and a simple average statewide labor rate will be determined.

b. A blended direct service worker labor rate will be calculated by comparing the simple average statewide labor rate to the most recently available, as of the calculation of the department's rate validation process, average personal care aide wage rate from the *Louisiana Occupational Employment and Wages* report for all Louisiana parishes published by the Louisiana Workforce Commission (or its successor).

i. If the simple average statewide labor rate is less than the wage rate from the *Louisiana Occupational Employment and Wages* report, a blended wage rate will be calculated using 50 percent of both wage rates.

ii. If the simple average statewide labor rate is equal to or greater than the wage rate from the *Louisiana Occupational Employment and Wages* report, the simple average statewide labor rate will be utilized.

c. An employee benefit factor will be added to the blended direct service worker wage rate to determine the unadjusted hourly staff cost.

i. Employee benefit expense allocated to reimbursable assistance services will be collected from provider cost reports.

ii. Employee benefit expense, on an individual cost report basis, will be divided by the cost report direct service wage and contract labor expense for reimbursable assistance services to calculate employee benefits as a percentage of labor costs.

iii. The individual cost report employee benefit percentages will be aggregated for all applicable filed cost reports, outliers will be removed, and a simple average statewide employee benefit percentage will be determined.

iv. The simple average statewide employee benefit percentage will be multiplied by the blended direct service worker labor rate to calculate the employee benefit factor.

d. The department will be solely responsible for determining if adjustments to the unadjusted hourly staff cost for items that are underrepresented or not represented in provider cost reports is considered appropriate.

e. The unadjusted hourly staff cost will be multiplied by a productive hours adjustment to calculate the hourly adjusted staff cost rate component total. The productive hours' adjustment allows the reimbursement rate to reflect the cost associated with direct service worker time spent performing required non-billable activities. The productive hours' adjustment will be calculated as follows:

i. The department will determine estimates for the amount of time a direct service worker spends performing required non-billable activities during an eight hour period. Examples of non-billable time include, but are not limited to: meetings, substitute staff, training, wait-time, supervising, etc.

ii. The total time associated with direct service worker non-billable activities will be subtracted from eight hours to determine direct service worker total billable time.

iii. Eight hours will be divided by the direct service worker total billable time to calculate the productive hours adjustment.

3. The other operational cost rate component will be calculated in the following manner:

a. Capital expense, transportation expense, other direct non-labor expense, and other overhead expense allocated to reimbursable assistance services will be collected from provider cost reports.

b. Capital expense, transportation expense, supplies and other direct non-labor expense, and other overhead expense, on an individual cost report basis, will be divided by the cost report direct service wage and contract labor expense

for reimbursable assistance services to calculate other operational costs as a percentage of labor costs.

c. The individual cost report other operational cost percentages will be aggregated for all applicable filed cost reports, outliers will be removed, and a simple average statewide other operational cost percentage will be determined.

d. The simple average other operational cost percentage will be multiplied by the blended direct service worker labor rate to calculate the other operational cost rate component.

4. The calculated department reimbursement rates will be adjusted to a one quarter hour unit of service by dividing the hourly adjusted staff cost rate component and the hourly other operational cost rate component totals by four.

5. The department will be solely responsible for determining the sufficiency of the current reimbursement rates during the rate validation process. Any reimbursement rate change deemed necessary due to rate validation process will be subject to legislative budgetary appropriation restrictions prior to implementation.

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 42:

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.

Rebekah E. Gee MD, MPH

Secretary

**RULE**

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

**Home and Community-Based Services Waivers  
Residential Options Waiver  
Unit of Reimbursement  
(LAC 50:XXI.16901 and 16903)**

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:XXI.16901 and §16903 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 13. Residential Options Waiver**

**Chapter 169. Reimbursement**

**§16901. Unit of Reimbursement**

A. Reimbursement for the following services shall be a prospective flat rate for each approved unit of service provided to the waiver participant. One quarter hour (15 minutes) is the standard unit of service and reimbursement shall not be made for

less than one quarter hour of service. This covers both the service provision and administrative costs for these services:

A.1. - J. ...

K. - L.1.d. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2456 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:1049 (April 2013), LR 41:2168, 2169 (October 2015), LR 42:63 (January 2016), LR 42:

**§16903. Direct Support Professional Wages**

A. The minimum hourly rate paid to direct support professionals shall be the federal minimum wage in effect at the time.

1. - 6. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2456 (November 2007), amended by the



Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2169 (October 2015), LR 42:

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.

Rebekah E. Gee MD, MPH

Secretary

**RULE**

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

**Home and Community-Based Services Waivers  
Supports Waiver  
Unit of Reimbursement  
(LAC 50:XXI.6101)**

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:XXI.6101 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 5. Supports Waiver**

**Chapter 61. Reimbursement**

**§6101. Unit of Reimbursement**

A. The reimbursement for all services will be paid on a per claim basis. The reimbursement rate covers both service provision and administration. Services which utilize a prospective flat rate of one quarter hour (15 minutes) will not be paid for the provision of less than one quarter hour of service.

B. - G. ...

H. Direct Support Professionals Wages. The minimum hourly rate paid to direct support professionals shall be the federal minimum wage in effect at the time.

1. - 9.d. Repealed.

I. ...

J. - L.1. Repealed

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1607 (September 2006), amended LR 34:662 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 36:2281 (October 2010), LR 37:2158 (July 2011), LR 39:1050 (April 2013), LR 40:82 (January 2014), LR 40:2587 (December 2014), LR 42:

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.

Rebekah E. Gee MD, MPH

Secretary

**RULE**

**Department of Health and Hospitals  
Bureau of Health Services Financing**

**Medicaid Eligibility  
Asset Verification Program  
(LAC 50:III.Chapter 3)**

The Department of Health and Hospitals, Bureau of Health Services Financing has adopted LAC 50:III.Chapter 3 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 III. Eligibility  
Subpart 1. General Administration**

**Chapter 3. Asset Verification Program**

**§301. General Provisions**

A. Pursuant to §7001(d) of the Supplemental Appropriations Act of 2008 (P.L. 110-252) and §1940 of the Social Security Act, the department hereby establishes provisions to implement an Asset Verification Program (AVP) for Louisiana Medicaid.

B. The department will provide for the verification of assets for the purposes of determining or redetermining (renewing) Medicaid eligibility for aged, blind and disabled

Medicaid applicants and recipients of Medicaid using an asset verification system (AVS) which meets the following requirements.

1. The request and response system will be an electronic system and meet the following criteria.

a. Verification inquiries will be sent electronically via the internet or similar means from Medicaid to the financial institution (FI).

b. The system will not be based on mailing paper-based requests.

c. The system will have the capability to accept responses electronically.

C. The system will be secure, based on a recognized industry standard of security.

D. The system will establish and maintain a database of the FIs that will participate in the department's AVS as mandated by federal 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, LR 42:

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.

Rebekah E. Gee MD, MPH

Secretary

**RULE**

**Department of Health and Hospitals  
Bureau of Health Services Financing**

**Medicaid Eligibility  
Recipient Appeals and Fair Hearing Requests  
(LAC 50:III.101)**

The Department of Health and Hospitals, Bureau of Health Services Financing has repealed and replaced the provisions of Section T-100 of the *Medicaid Eligibility Manual* governing fair hearings which was promulgated in the May 20, 1996 Rule, and has adopted LAC 50:III.101 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 III. Eligibility  
Subpart 1. General Administration**

**Chapter 1. General Provisions**

**§101. Fair Hearings**

A. Every applicant for, and enrollee of, Medicaid Program benefits has the right to appeal an agency action or decision, and has the right to request a fair hearing in the presence of an impartial hearing officer.

1. *Action*-a termination, suspension or reduction of Medicaid eligibility or covered services. This includes terminations by skilled nursing facilities and nursing facilities to transfer or

discharge residents and adverse determinations made by a State (Medicaid Program) with regard to the preadmission screening and annual resident review requirements of §1917(e)(7) of the Social Security Act.

2. Exception. Enrollees are not entitled to a fair hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all Medicaid recipients.

3. Applicants and enrollees shall be informed in writing of the right to request a fair hearing and of the procedure to do so.

B. The Medicaid Program may delegate the responsibility for conducting fair hearings to another state agency. Any agency with delegated authority to conduct fair hearings on behalf of the Medicaid Program shall comply with the federal notice and fair hearing requirements pursuant to 42 CFR 431, Subpart E, and all other Medicaid Program and state regulations governing fair hearings.

C. Applicants and enrollees must request a fair hearing within 30 days of the date of the adequate and/or timely decision notice issued by the Medicaid Program or its designee.

D. Maintenance of Services Pending a Fair Hearing Request

1. If the Medicaid Program sends a notice to the recipient as required under 42 CFR 431.211 or §431.214, and the recipient requests a hearing before the date of action, the



recipient's services will not be terminated or reduced by the Medicaid Program until a decision is rendered after the hearing unless:

a. it is determined at the hearing that the sole issue is one of federal or state law or policy; and

b. the recipient is promptly informed by Medicaid, in writing, that the services are to be terminated or reduced pending the hearing decision.

2. If the Medicaid Program's action is sustained by the hearing decision, recovery procedures may be instituted against the applicant/recipient to recoup the cost of any services furnished, to the extent they were furnished solely by reason of this §101.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, Bureau of Health Services Financing, LR 42:

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.

Rebekah E. Gee MD, MPH

Secretary

**RULE**

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

**Personal Care Services - Long-Term**  
**(LAC 50:XV.Chapter 129)**

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services have amended LAC 50:XV.Chapter 129 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 XV. Services for Special Populations  
Subpart 9. Personal Care Services**

**Chapter 129. Long Term Care**

**§12901. General Provisions**

A. - F.1.b. ...

2. The functions of a responsible representative are to:

a. assist or represent, as needed, the recipient in the assessment, care plan development and service delivery processes; and

F.2.b. - G.3. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:911 (June 2003), amended LR 30:2831 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 32:2082 (November 2006), LR 34:2577 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2450 (November 2009), LR 39:2506 (September 2013), LR 41:540 (March 2015), LR 42:

**§12902. Participant Direction Option**

Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2578 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2507 (September 2013), repealed LR 42:

**§12903. Covered Services**

A. *Personal care services* are defined as those services

that provide assistance with the distinct tasks associated with the performance of the activities of daily living (ADLs) and the instrumental activities of daily living (IADLs). Assistance may be either the actual performance of the personal care task for the individual or supervision and prompting so the individual performs the task by him/herself. ADLs are those personal, functional activities required by the recipient. ADLs include tasks such as:

1. - 4. ...

5. *transferring*-the manner in which an individual moves from one surface to another (excludes getting on and off the toilet, and getting in and out of the tub/shower);

A.6. - C. ...

1. If transportation is furnished, the participant must accept all liability for their employee transporting them. It is the responsibility of the participant to ensure that the employee has a current, valid driver's license and automobile liability insurance.

a. Repealed.

D. ...

E. For participants receiving LT-PCS with the Adult Day Health Care (ADHC) Waiver, personal care services may be provided by one worker for up to three long-term personal care service recipients who live together, and who have a common

direct service provider.

F. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:912 (June 2003), amended LR 30:2831 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2578 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2507 (September 2013), LR 42:

**§12905. Eligibility Criteria**

A. Personal care services shall be available to recipients who are 65 years of age or older, or 21 years of age or older and have a disability. Persons with a disability must meet the disability criteria established by the Social Security Administration.

B. - B.3.c. ...

C. Persons designated as the responsible representative of an individual receiving services under LT-PCS may not be the paid direct service worker of the individual they are representing.

D. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:912 (June 2003), amended LR 30:2831 (December 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services, LR 32:2082 (November 2006), LR 34:2579 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2507 (September 2013), LR 42:

**§12907. Recipient Rights and Responsibilities**

A. Recipients who receive services under the Long-Term Personal Care Services Program have the right to actively participate in the development of their plan of care and the decision-making process regarding service delivery. Recipients also have the right to freedom of choice in the selection of a provider of personal care services and to participate in the following activities:

1. - 6. ...

7. changing the personal care worker assigned to provide their services;

A.8. - B. ...

C. - C.13. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:912 (June 2003), amended LR 30:2832 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2579 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2508 (September 2013), LR 42:

**§12910. La POP Standards for Participation**

Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2580 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and Office of Aging and Adult Services, LR 39:2508 (September 2013), repealed LR 42:

**§12911. Staffing Requirements**

A. All staff providing direct care to the recipient must meet the qualifications for furnishing personal care services per the licensing regulations. The direct service worker shall

demonstrate empathy toward the elderly and persons with disabilities, an ability to provide care to these recipients, and the maturity and ability to deal effectively with the demands of the job.

B. - B.1.f. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2832 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2580 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2508 (September 2013), LR 42:

**§12912. Training**

Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2580 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2509 (September 2013), repealed



LR 42:

**§12913. Service Delivery**

A. ...

B. The provision of services outside of the recipient's home does not include trips outside of the borders of the state without approval of OAAS or its designee.

C. Participants are not permitted to live in a home or property owned, operated, or controlled by an owner, operator, agent, or employee of a licensed provider of long-term care services, and providers are prohibited from providing and billing for services under these circumstances. Participants may not live in the home of a direct support worker unless the direct support worker is related by blood or marriage to the participant.

1. ...

D. Place(s) of service must be documented in the plan of care and service logs.

E. It is permissible for an LT-PCS recipient to use his/her approved LT-PCS weekly allotment flexibly provided that it is done so in accordance with the recipient's preferences and personal schedule and is properly documented in accordance with OAAS policy.

F. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S.

36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:913 (June 2003), amended LR 30:2833 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2581 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Financing and the Office of Aging and Adult Services, LR 39:2509 (September 2013), LR 42:

**§12917. Unit of Reimbursement**

A. Reimbursement for personal care services shall be a prospective flat rate for each approved unit of service that is provided to the recipient. One quarter hour (15 minutes) is the standard unit of service for personal care services.

Reimbursement shall not be paid for the provision of less than one quarter hour (15 minutes) of service. Additional reimbursement shall not be available for transportation furnished during the course of providing personal care services.

B. The minimum hourly rate paid to personal care workers shall be at least the current federal minimum.

B.1. - I. Repealed

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

HISTORICAL NOTE: Promulgated by the Department of Health

and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:913 (June 2003), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:253 (February 2008), LR 34:2581 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:1901 (September 2009), LR 36:1251 (June 2010), LR 37:3267 (November 2011), LR 39:1780 (July 2013), LR 42:

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.

Rebekah E. Gee MD, MPH

Secretary