NOTICE OF INTENT

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

Home and Community-Based Services Waivers
Community Choices Waiver
(LAC 50:XXI.Chapters 81-87 and 93)

The Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services propose to amend LAC 50:XXI.Chapters 81-87 and 93 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services (OAAS) propose to amend the provisions governing the Community Choices Waiver (CCW) in order to: 1) align the provisions governing target population, service definitions and provider qualifications with the waiver approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services; 2) eliminate the non-medical transportation service; 3) amend the criteria for CCW priority offers to specify priority for individuals admitted to, or residing in, nursing facilities for whom Medicaid is the sole payer source; 4) change

references to the minimum data set-home care to the International Resident Assessment Instrument (interRAI) assessment tool; and 5) allow OAAS to grant exceptions to waiver discharges for interruptions due to qualifying circumstances.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XXI. Home and Community Based Services Waivers
Subpart 7. Community Choices Waiver

Chapter 81. General Provisions

§8101. Introduction

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

1. are 65 years of age or older; or

2. are 21-64 years of age with a physical disability; and

3. meet nursing facility level of care requirements.

4. Repealed.

B. - D.2. ...

3. No individual, unless granted an exception by OAAS, may concurrently serve as a responsible representative for more than two participants in OAAS-operated Medicaid home and community-based service programs. This includes but is not limited to:

a. - 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 and the Office of Aging and Adult Services, LR 37:3517 (December 2011), amended LR 40:791 (April 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8103. Request for Services Registry

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

B. Individuals who desire their name to be placed on the Community Choices Waiver registry shall be screened to determine whether they meet:

1. nursing facility level or care; and

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

C. Only individuals who pass the screen required in §8103.B.1-2 shall be added to the registry.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3517 (December 2011), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8105. Programmatic Allocation of Waiver Opportunities

A. ...

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

1. individuals with substantiated cases of abuse or neglect referred by protective services who, without Community Choices Waiver services, would require institutional placement to prevent further abuse or neglect;

2. - 3. ...

4. individuals admitted to or residing in a nursing facility who have Medicaid as the sole payer source for the nursing facility stay;

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

a. Adult Day Health Care (ADHC) Waiver;

b. New Opportunities Waiver (NOW);

c. Supports Waiver, and/or

d. Residential Options Waiver (ROW); and

B.6. - C. ...

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

E. Notwithstanding the priority group provisions, up to 300 Community Choices Waiver opportunities may be granted to qualified individuals who require emergency waiver services. These individuals shall be offered an opportunity on a first-come, first-serve basis.

1. To be considered for an expedited waiver opportunity, the individual must, at the time of the request for the expedited opportunity, be approved for the maximum amount of services allowable under the long -term personal care services and require institutional placement, unless offered an expedited waiver opportunity.

2. - 2.e. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3517 (December 2011), amended LR 39:319 (February 2013), LR 39:1778 (July 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8107. Resource Assessment Process

A. Each Community Choices Waiver applicant/participant shall be assessed using the uniform International Resident Assessment Instrument (interRAI) designed to verify that an individual meets nursing facility level of care and to assess multiple key domains of function, health, social support and service use. The interRAI assessment generates a score that assigns the individual to a resource utilization group (RUG-III/HC).

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

1. Special Rehabilitation. Individuals in this category have had at least 120 minutes of rehabilitation therapy

(physical, occupational and/or speech) within the seven days prior to their interRAI assessment.

2. - 2.c. ...

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

a. - f. ...

g. intravenous (IV) medications; or

B.3.h. - C.1. ...

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

a. one or more answers are incorrect as recorded on the assessment (except for the answers in the identification information, personal intake and initial history, assessment date and reason, and/or signature sections); or

b. ...

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

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

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

amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Chapter 83. Covered Services

§8301. Support Coordination

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

1. intake;

2. assessment and re-assessment;

3. plan of care development and revision;

4. follow-up/monitoring;

5. critical incident management; and

6. transition/discharge and closure.

7. - 12. Repealed.

B. ...

1. When participants choose to self-direct their waiver services, the support coordinators are responsible for informing participants about:

a. ...

b. how their activities as an employer are coordinated with the fiscal agent; and

1.c. - 2. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3519 (December 2011), amended LR 39:319 (February 2013), LR 39:1778 (July 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8302. Long-Term Personal Care Services

A. Community Choices Waiver participants cannot also receive long-term personal care services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:320 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8303. Transition Intensive Support Coordination

A. Transition intensive support coordination services assist participants who are currently residing in nursing

facilities in gaining access to needed waiver and other state plan services, as well as needed medical, social, housing, educational and other services, regardless of the funding source for these services. Support coordinators shall initiate and oversee the process for assessment and reassessment, as well as be responsible for ongoing monitoring of the provision of services included in the participant's approved POC.

1. - 2. ...

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3519 (December 2011), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8305. Environmental Accessibility Adaptations

A. Environmental accessibility adaptations are necessary physical adaptations that will be made to the home to reasonably assure the health and welfare of the participant, or enable the participant to function with greater independence in the home.

1. There must be an identified need for environmental accessibility adaptations as indicated by:

a. the interRAI assessment; or

b. supporting documentation of the need.

2. A credentialed environmental accessibility adaptation assessor must complete a written report that includes:

a. verification of the need for the adaptation(s);

b. draft job specifications; and

c. cost estimates for completion of the environmental accessibility adaptation(s).

3. The work must be completed by an enrolled, licensed contractor.

4. Environmental accessibility adaptation(s)shall meet all job specifications as outlined in the written report before payment is made to the contractor that performed the environmental accessibility adaptation(s).

a. If final inspection, either by OAAS staff or the assessor, reveals that the adaptation(s) is substandard, the costs of correcting the work will be the responsibility of the party in error.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3519 (December 2011), amended LR 39:320 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8307. Personal Assistance Services

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

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

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

A.3. - B. ...

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

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

1. - 2. ...

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

4. - 6. ...

7. "a.m." and/or "p.m." PAS may not be provided on the same calendar day as other PAS delivery methods;

D.8. - F. ...

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

H. Every PAS provider shall ensure timely completion of the emergency plan for each waiver participant they serve.

I. - I.6. ...

J. Participants are not permitted to receive PAS while living 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 that worker is related by blood or marriage to the participant.

1. ...

K. It is permissible for the PAS allotment to be used flexibly within a prior authorized week in accordance with the participant's preferences and personal schedule and with proper documentation.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3519 (December 2011), amended LR 39:320 (February 2013), LR 39:1778 (July 2013), LR 40:791 (April 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8309. Transition Services

A. ...

B. Allowable expenses are those necessary to enable the individual to establish a basic household (excluding expenses for room and board)including, but not limited to:

1. ...

2. specific set up fees or deposits;

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

4. essential furnishings to establish basic living arrangements; and

5. health and welfare assurances.

C. ...

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

E. ...

F. Funds are available up to the lifetime maximum amount identified in the federally-approved waiver document.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3520 (December 2011), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8311. Adult Day Health Care Services

A. ...

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

1. medical care management; and

2. transportation to and from medical and social activities (if the participant is accompanied by the ADHC center staff).

3. - 8. Repealed.

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 37:3521 (December 2011), amended LR 39:321 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8313. Caregiver Temporary Support Services

A. - H. ...

I. Caregiver temporary support may be provided for the relief of the principal caregiver for participants who receive monitored in-home caregiving (MIHC) services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3521 (December 2011), amended LR 39:321 (February 2013), LR 40:792 (April 2014),

amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8315. Assistive Devices and Medical Supplies

A. Assistive devices and medical supplies are specialized medical equipment and supplies which include:

1. devices, controls, appliances or nutritional supplements that enable participants to increase their ability to perform activities of daily living; or

2. devices, controls, appliances or nutritional supplements that enable participants to perceive, control, or communicate with the environment in which they live or provide emergency response;

3. items, supplies and services necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items;

4. supplies and services necessary to assure health and welfare;

5 other durable and non-durable medical equipment and medical supplies that are necessary, but not available under the state plan;

6. personal emergency response systems (PERS);

7. other in-home monitoring and medication management devices and technology;

8. routine maintenance or repair of specialized equipment; and

9. batteries, extended warranties, and service contracts that are cost effective and assure health and welfare.

B. This service includes medical equipment, not available under the state plan, that is necessary to address participant functional limitations and necessary medical supplies not available under the state plan.

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

D. All services must be based on a verified need of the participant and the service must have a direct or remedial benefit to the participant with specific goals and outcomes. This benefit must be determined by an independent assessment on any items whose cost exceeds the amount identified in the federally-approved waiver document and on all communication devices, mobility devices, and environmental controls. Independent assessments are done by individuals who have no fiduciary relationship with the manufacturer, supplier, or vendor of the item.

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

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

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

H. 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 37:3521 (December 2011), amended LR 39:321 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8319. Non-Medical Transportation

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 37:3522 (December 2011), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8323. Skilled Maintenance Therapy

A. Skilled maintenance therapy is therapy services that may be received by participants in the home or rehabilitation center.

B. ...

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

D. - H. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3522 (December 2011), amended LR 39:321 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8325. Housing Transition or Crisis Intervention Services

A. Housing transition or crisis intervention services enable participants who are transitioning into a permanent supportive housing (PSH)unit, including those transitioning from institutions, to secure their own housing or provide assistance at any time the participant's housing is placed at risk (e.g.,

eviction, loss of roommate or income). The service includes the following components:

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

a. ...

b. becoming familiar with neighborhood, resources, and neighbors;

c. meeting the terms of a lease;

d. eviction prevention;

e. budgeting for housing/living expenses;

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

g. home management; and

h. ...

2. assisting the participant to view and secure housing as needed. This may include arranging or providing transportation. The participant shall be assisted in securing supporting documents/records, completing/submitting applications, securing/seeking waiver of deposits, and locating furnishings;

3. - 5. ...

6. communicating with the landlord or property manager regarding:

a. accommodations needed by the participant;

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

c. needs to assist with issues that may place the participant's ability to access or remain in housing at risk.

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 39:1779 (July 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8327. Housing Stabilization Services

A. Housing stabilization services enable waiver participants to, once housed, successfully maintain tenancy and residence in their own housing as set forth in the participant's approved plan of care. Services must be provided in the home or a community setting. This service includes the following components:

1. ...

2. providing supports and interventions designed to maintain ongoing successful and stable tenancy and residence;

3. serving as point of contact for the landlord or property manager regarding any accommodations needed by the participant, any components of emergency procedures involving the landlord or property manager and to assist with issues that may place the participant's housing at risk; and

A.4. - B. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:1779 (July 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8329. Monitored In-Home Caregiving Services

A. ...

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

1. - 4. ...

5. supervision or assistance while escorting/ accompanying the individual outside of the home to perform

services indicated in the plan of care and to provide the same level of supervision or assistance as would be rendered in the home; and

B.6. - C.5. ...

D. Participants electing monitored in-home caregiving services shall not receive the following Community Choices Waiver services during the period of time that the participant is receiving monitored in-home caregiving services:

1. - 3. ...

E. Monitored in-home caregiving providers must be licensed HCBS providers with a monitored in-home caregiving module who employ professional staff, including a registered nurse and a care manager, to support principal caregivers to perform the direct care activities performed in the home. The provider must assess and approve the home in which services will be provided, and shall enter into contractual agreements with caregivers who the agency has approved and trained. The provider will pay per diem stipends to caregivers.

F. The MIHC provider must use secure, web-based information collection from principal caregivers for the purposes of monitoring participant health and caregiver performance. All protected health information (PHI) must be transferred, stored, and otherwise utilized in compliance with applicable federal and state privacy laws. Providers must sign,

maintain on file, and comply with the LDH HIPAA business associate addendum.

G. The department shall reimburse for monitored in-home caregiving services based upon a tiered model which is designed to address the participant's acuity.

1. - 2.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, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 40:792 (April 2014), amended LR 41:2642 (December 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Chapter 85. Self-Direction Initiative

§8501. Self-Direction Service Option

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

B. - C. ...

1. Voluntary Termination. A waiver participant may choose at any time to withdraw from the self-direction service option and return to the traditional direct service provider.

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

a. - c. ...

d. the participant or responsible representative:

i. - ii. ...

iii. fails to provide required documentation;

iv. fails to cooperate with the department fiscal agent or support coordinator;

v. ...

vi. fails to receive self-directed services for 90 calendar days or more.

D. Employee Qualifications. All employees under the self-direction option must:

1. be at least 18 years of age on the date of hire;

2. pass required criminal background checks; and

3. be able to complete the tasks identified in the plan of care.

E. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3523 (December 2011), amended LR 39:321 (February 2013), LR 39:1779 (July 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Chapter 86. Organized Health Care Delivery System

§8601. General Provisions

A. - B. ...

C. The OHCDS must attest that all applicable provider qualifications are met.

D. Prior to enrollment, an OHCDS must show the ability to provide all of the following community choices services :

1. personal assistance services (PAS);

2. home delivered meals;

3. skilled maintenance therapy;

4. nursing;

5. caregiver temporary support services;

6. assistive devices and medical supplies;

7. environmental accessibility adaptations (EAA); and

8. adult day health care (only if there is a licensed ADHC provider in the service area).

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 40:792 (April 2014), amended LR 41:2643 (December 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Chapter 87. Plan of Care

§8701. Plan of Care

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

POC shall be developed using a person-centered process coordinated by the support coordinator.

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

C. - C.2. ...

3. total cost of waiver services covered by the POC.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3524 (December 2011), amended LR 39:321 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Chapter 89. Admission and Discharge Criteria

§8901. Admission Criteria

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

1. - 4. ...

5. reasonable assurance that the health and welfare of the participant can be maintained in the community with the provision of Community Choices Waiver services.

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3524 (December 2011), amended LR 39:322 (February 2013); amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8903. Admission Denial or Discharge Criteria

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

1. The individual does not meet the target population criteria as specified in the federally approved waiver document.

2. The individual does not meet the criteria for Medicaid financial eligibility.

3. The individual does not meet the criteria for nursing facility level of care.

4. ...

5. Continuity of services is interrupted as a result of the participant not receiving and/or refusing community choices waiver services (exclusive of support coordination services) for a period of 30 consecutive days.

EXCEPTION: An exception may be granted by OAAS to delay discharge if interruption is due to an acute care hospital, rehabilitation hospital, or nursing facility admission. 6. The health and welfare of the individual cannot be reasonably assured through the provision of Community Choices Waiver services.

7. - 8. ...

9. It is not cost effective or appropriate to serve the individual in the Community Choices Waiver.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3524 (December 2011), amended LR 39:322 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Chapter 93. Provider Responsibilities

§9301. General Provisions

A. ...

B. The provider shall not request payment unless the participant for whom payment is requested is receiving services in accordance with the Community Choices Waiver program provisions and the services have been prior authorized and actually provided.

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

1. - 2. ...

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

E. Any provider of services under the Community Choices Waiver shall not interfere with the eligibility, assessment, care plan development, or care plan monitoring processes with use of methods including, but not limited to:

1. - 2. ...

3. threats against program participants, members of their informal support network, LDH staff or support coordination staff.

F. Any provider of services under the Community Choices Waiver shall have the capacity and resources to provide all aspects of any service they are enrolled to provide in the specified service area.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3524 (December 2011), amended LR 39:322 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§9303. Reporting Requirements

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

B. ...

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), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Chapter 95. Reimbursement

§9501. Unit of Reimbursement

A. - A.6. ...

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

1. ...

2. environmental accessibility adaption assessment and inspections;

3. assistive devices and medical supplies;

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

5. transition services (not to exceed the maximum lifetime limit set by OAAS);

6. monitored in-home caregiving (MIHC) assessment; and

7. certain nursing, and skilled maintenance therapy procedures

C. - D.3. ...

E. 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.

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

F.1. - H. 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, 508 (March 2013), repromulgated LR 39:1048 (April 2013), amended LR 39:1779 (July 2013), LR 40:793 (April 2014), LR 42:897 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services

(CMS), if it is determined that submission to CMS for review and approval is required.

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

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

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

Interested persons may submit written comments to Jen Steele, Bureau of Health Services Financing, P.O. Box 91030,

Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Steele is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Wednesday, August 29, 2018 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Rebekah E. Gee MD, MPH

Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES

Person Preparing Statement: Veronica Dent
Phone: 342-3238

Dept.: Health
Office: Bureau of Health Services Financing

Return Address: P.O. Box 91030
Baton Rouge, LA

Rule Title: Home and Community-Based Services Waivers
Community Choices Waiver

Date Rule Takes Effect: October 20, 2018

SUMMARY

In accordance with Section 953 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a fiscal and economic impact statement on the rule proposed for adoption, repeal or amendment. The following summary statements, based on the attached worksheets, will be published in the Louisiana Register with the proposed agency rule.

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (SUMMARY)

It is anticipated that implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 18-19. It is anticipated that $3,888 ($1,944 SGF and $1,944 FED) will be expended in FY 18-19 for the state's administrative expense for promulgation of this proposed rule and the final rule.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed Rule will not affect revenue collections other than the federal share of the promulgation costs for FY 18-19. It is anticipated that $1,944 will be collected in FY 18-19 for the federal share of the expense for promulgation of this proposed rule and the final rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NON-GOVERNMENTAL GROUPS (Summary)

This proposed Rule amends the provisions governing the Community Choices Waiver in order to: 1) align the provisions governing target population, service definitions and provider qualifications with the waiver approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services; 2) eliminate the non-medical transportation service; 3) amend the criteria for CCW priority offers to specify priority for individuals admitted to, or residing in, nursing facilities for whom Medicaid is the sole payer source; 4) change references to the minimum data set-home care to the International Resident Assessment Instrument (interRAI) assessment tool; and 5) allow OAAS to grant exceptions to waiver discharges for interruptions due to qualifying circumstances. There is no anticipated impact as a result of this proposed rule because there is no change in the reimbursement methodology and the service being eliminated has never been requested nor utilized since implementation. It is anticipated that implementation of this proposed rule will not have economic costs or benefits to Community Choice Waiver providers for FY 18-19, FY 19-20 and FY 20-21.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

Signature of Agency Head or Designee

Evan Brasseaux, Staff Director
Legislative Fiscal Officer or Designee

Jen Steele, Medicaid Director
Typed name and Title of Agency Head or Designee

7/10/18
Date of Signature

Blythe Ford
LDH/BHSF Budget Head

07/10/18
Date of Signature

FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES

The following information is required in order to assist the Legislative Fiscal Office in its review of the fiscal and economic impact statement and to assist the appropriate legislative oversight subcommittee in its deliberations on the proposed rule.

A. Provide a brief summary of the content of the rule (if proposed for adoption or repeal) or a brief summary of the change in the rule (if proposed for amendment). Attach a copy of the notice of intent and a copy of the rule proposed for initial adoption or repeal (or, in the case of a rule change, copies of both the current and proposed rules with amended portions indicated).

This proposed Rule amends the provisions governing the Community Choices Waiver in order to: 1) align the provisions governing target population, service definitions and provider qualifications with the waiver approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services; 2) eliminate the non-medical transportation service; 3) amend the criteria for CCW priority offers to specify priority for individuals admitted to, or residing in, nursing facilities for whom Medicaid is the sole payer source; 4) change references to the minimum data set-home care to the International Resident Assessment Instrument (interRAI) assessment tool; and 5) allow OAAS to grant exceptions to waiver discharges for interruptions due to qualifying circumstances.

B. Summarize the circumstances that require this action. If the action is required by federal regulations, attach a copy of the applicable regulation.

The Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services (OAAS) propose to amend the provisions governing the Community Choices Waiver (CCW) in order to: 1) align the provisions governing target population, service definitions and provider qualifications with the waiver approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services; 2) eliminate the non-medical transportation service; 3) amend the criteria for CCW priority offers to specify priority for individuals admitted to, or residing in, nursing facilities for whom Medicaid is the sole payer source; 4) change references to the minimum data set-home care to the International Resident Assessment Instrument (interRAI) assessment tool; and 5) allow OAAS to grant exceptions to waiver discharges for interruptions due to qualifying circumstances.

C. Compliance with Act 11 of the 1986 First Extraordinary Session

(1) Will the proposed rule change result in any increase in the expenditure of funds? If so, specify amount and source of funding.

No. It is anticipated that implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 18-19. It is anticipated that $3,888 will be expended in FY 18-19 for the state's administrative expense for promulgation of this proposed rule and the final rule.

(2) If the answer to (1) above is yes, has the Legislature specifically appropriated the funds necessary for the associated expenditure increase?

(a) ____ If yes, attach documentation.
(b) ____ If no, provide justification as to why this rule change should be published at this time.

FISCAL AND ECONOMIC IMPACT STATEMENT
WORKSHEET

I. A. COST OR SAVINGS TO STATE AGENCIES RESULTING FROM THE ACTION PROPOSED

1. What is the anticipated increase or (decrease) in cost to implement the proposed action?

COST	FY 18-19	FY 19-20	FY 20-21
PERSONAL SERVICES			
OPERATING EXPENSES	$3,888	$0	$0
PROFESSIONAL SERVICES			
OTHER CHARGES			
REPAIR & CONSTR.			
POSITIONS (#)			
TOTAL	**$3,888**	**$0**	**$0**

2. Provide a narrative explanation of the costs or savings shown in "A.1.", including the increase or reduction in workload or additional paperwork (number of new forms, additional documentation, etc.) anticipated as a result of the implementation of the proposed action. Describe all data, assumptions, and methods used in calculating these costs.

In FY 18-19, $3,888 will be spent for the state's administrative expense for promulgation of this proposed rule and the final rule.

3. Sources of funding for implementing the proposed rule or rule change.

Source	FY 18-19	FY 19-20	FY 20-21
STATE GENERAL FUND	$1,944	$0	$0
SELF-GENERATED			
FEDERAL FUND	$1,944	$0	$0
OTHER (Specify)			
Total	**$3,888**	**$0**	**$0**

4. Does your agency currently have sufficient funds to implement the proposed action? If not, how and when do you anticipate obtaining such funds?

Yes, sufficient funds are available to implement this rule.

B. COST OR SAVINGS TO LOCAL GOVERNMENTAL UNITS RESULTING FROM THIS PROPOSED ACTION.

1. Provide an estimate of the anticipated impact of the proposed action on local governmental units, including adjustment in workload and paperwork requirements. Describe all data, assumptions and methods used in calculating this impact.

This proposed rule has no known impact on local governmental units.

2. Indicate the sources of funding of the local governmental unit that will be affected by these costs or savings.

There is no known impact on the sources of local governmental unit funding.

II. EFFECT ON REVENUE COLLECTIONS OF STATE AND LOCAL GOVERNMENTAL UNITS

A. What increase or (decrease) in revenues can be expected from the proposed action?

REVENUE INCREASE/DECREASE	**FY 18-19**	**FY 19-20**	**FY 20-21**
STATE GENERAL FUND			
AGENCY SELF-GENERATED			
RESTRICTED FUNDS*			
FEDERAL FUNDS	$1,944	$0	$0
LOCAL FUNDS			
Total	**$1,944**	**$0**	**$0**

Specify the particular fund being impacted

B. Provide a narrative explanation of each increase or decrease in revenue shown in "A". Describe all data, assumptions, and methods used in calculating these increases or decreases.

In FY 18-19, $1,944 will be collected for the federal share of the administrative expense for promulgation of this proposed rule and the final rule.

III. COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NON-GOVERNMENTAL GROUPS

A. What persons or non-governmental groups would be directly affected by the proposed action? For each, provide an estimate and a narrative description of any effects on costs, including workload adjustments and additional paperwork (number of new forms, additional documentation, etc.)

This proposed Rule amends the provisions governing the Community Choices Waiver in order to: 1) align the provisions governing target population, service definitions and provider qualifications with the waiver approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services; 2) eliminate the non-medical transportation service; 3) amend the criteria for CCW priority offers to specify priority for individuals admitted to, or residing in, nursing facilities for whom Medicaid is the sole payer source; 4) change references to the minimum data set-home care to the International Resident Assessment Instrument (interRAI) assessment tool; and 5) allow OAAS to grant exceptions to waiver discharges for interruptions due to qualifying circumstances.

B. Also, provide an estimate of any revenue impact resulting from this rule or rule change to these groups.

There is no anticipated impact as a result of this proposed rule because there is no change in the reimbursement methodology and the service being eliminated has never been requested nor utilized since implementation. It is anticipated that implementation of this proposed rule will not have economic costs or benefits to Community Choice Waiver providers for FY 18-19, FY 19-20 and FY 20-21.

IV. EFFECTS ON COMPETITION AND EMPLOYMENT

Identify and provide estimates of the impact of the proposed action on competition and employment in the public and private sectors. Include a summary of any data, assumptions and methods used in making these estimates.

This rule has no known effect on competition and employment.