**NOTICE OF INTENT**

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

**Home and Community-Based Services Waivers**
**New Opportunities Waiver**
**Dental Services**
**(LAC 50:XXI.Chapters 137-143)**

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities propose to amend LAC 50:XXI.Chapters 137–143 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.

Act 450 of the 2021 Regular Session of the Louisiana Legislature directed the Department of Health to provide dental care to each person age 21 or older enrolled in any Medicaid waiver program for persons with developmental or intellectual disabilities. In compliance with Act 450, the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities propose to amend the provisions governing the New Opportunities Waiver in order to add adult dental services as a covered service. The department also proposes to amend the provisions governing the delivery of services in the New Opportunities Waiver under certain

conditions including allowing family members as paid caregivers, the 16-hour rule and shared services.

**Title 50**

**PUBLIC HEALTH-MEDICAL ASSISTANCE**
**Part XXI. Home and Community-Based Services Waivers**
**Subpart 11. New Opportunities Waiver**

**Chapter 137. General Provisions**

**§13701. Introduction**

A. The New Opportunities Waiver (NOW), hereafter referred to as the NOW, is designed to enhance the home and community-based services and supports available to individuals with developmental disabilities, who would otherwise require an intermediate care facility for persons with developmental disabilities (ICF-IDD) level of care. The mission of the NOW is to utilize the principle of self-determination and supplement the family and/or community supports while supporting the dignity, quality of life and security in the everyday life of an individual, and maintaining that individual in the community. Services provided in the NOW are community-based, and are designed to allow an individual experience that mirrors the experiences of individuals without disabilities. These services are not to be restrictive, but liberating, by empowering individuals to experience life in the most fulfilling manner as defined by the individual while still assuring health and safety. In keeping with the principles of self-determination,

NOW includes a self-direction service delivery option. This allows for greater flexibility in hiring, training, and general service delivery issues.

B. All NOW services are accessed through the case management agency of the beneficiary's choice. All services must be prior authorized and delivered in accordance with the approved comprehensive plan of care (CPOC). The CPOC shall be developed using a person-centered process coordinated by the beneficiary's case manager.

C. ...

D. In order for the NOW provider to bill for services, the beneficiary and the direct service provider, professional or other practitioner rendering service, must be present at the time the service is rendered unless otherwise allowed in rule. The service must be documented in service notes describing the service rendered and progress towards the beneficiary's personal outcomes and CPOC.

E. - E.3.av. ...

F. The average beneficiary expenditures for all waiver services shall not exceed the average Medicaid expenditures for ICF-IDD services.

G. 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 30:1201 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1647 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:68 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:50 (January 2018), LR 45:42 (January 2019), LR 46:1680 (December 2020), LR 48:

**§13702. Settings for Home and Community-Based Services**

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

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:51 (January 2018), LR 48:

**§13703. Beneficiary Qualifications and Admissions Criteria**

A. In order to qualify for the New Opportunities Waiver (NOW), an individual must be three years of age or older and meet all of the following criteria:

1. – 3. ...

4. meet the requirements for an ICF-IDD level of care which requires active treatment of a developmental disability under the supervision of a qualified developmental disability professional;

5. – 8. ...

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 30:1201 (June 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:96 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office

for Citizens with Developmental Disabilities, LR 43:2528 (December 2017), LR 45:43 (January 2019), LR 48:

**§13704. Needs-Based Assessment**

A. A uniform needs-based assessment in conjunction with person-centered planning is utilized in the service planning process for the individuals receiving or participating in an OCDD waiver. The results of this assessment activity shall be utilized to determine which OCDD waiver will be offered to the individual during the initial plan of care process.

1. The beneficiary or his/her representative may request a reconsideration and present supporting documentation if he/she disagrees with the specific OCDD waiver offered as a result of the needs based assessment and person-centered planning process. If the beneficiary disagrees with the reconsideration decision, he/she may request a fair hearing through the formal appeals process.

B. – C.4.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 Service Financing and the Office for Citizens with Developmental Disabilities, LR 36:65 (January 2010), amended LR 40:69 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and

the Office for Citizens with Developmental Disabilities, LR 43:2528 (December 2017), LR 48:

**§13705. Denial of Admission or Discharge Criteria**

A. Individuals shall be denied admission to or discharged from the NOW if one of the following criteria is met:

1. ...

2. the individual does not meet the requirement for an ICF-IDD level of care;

4. ...

5. the beneficiary is admitted to an ICF-IDD facility or nursing facility with the intent to stay and not to return to waiver services. The waiver beneficiary may return to waiver services when documentation is received from the treating physician that the admission is temporary and shall not exceed 90 days. The beneficiary will be discharged from the waiver on the ninety-first day if the beneficiary is still in the ICF-IDD or nursing facility;

6. the health and welfare of the beneficiary cannot be assured through the provision of NOW services within the beneficiary’s approved comprehensive plan of care;

7. ...

8. continuity of services is interrupted as a result of the individual not receiving a NOW service during a period of 30 or more consecutive days. This does not include interruptions

in NOW services because of hospitalization, temporary admission to rehabilitation or nursing facilities, or non-routine lapses in services where the family agrees to provide all needed or paid natural supports. There must be documentation from the treating physician that this interruption will not exceed 90 days in the case of the admission to a rehabilitation or nursing facility. During this 90-day period, the Office for Citizens with Developmental Disabilities (OCDD) will not authorize payment for NOW services; and/or

9. there is no justification, based on a uniform needs-based assessment and a person-centered planning discussion, that the NOW is the only OCDD waiver that will meet the beneficiary's needs.

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 30:1202 (June 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities LR 40:69 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:51 (January 2018), LR 45:43 (January 2019), LR 48:

**§13706. Resource Allocation**

A. ...

1. The beneficiary or his/her representative may request a reconsideration and present supporting documentation if he/she disagrees with the amount of assigned IFS service units. If the beneficiary disagrees with the reconsideration decision, he/she may request a fair hearing through the formal appeals process.

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, Bureau of Health Service Financing and the Office for Citizens with Developmental Disabilities, LR 43:2528 (December 2017), LR 48:

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

A. The intellectual/developmental disabilities request for services registry, hereafter referred to as “the registry,” is the list that documents and maintains the person’s name and protected request date for waiver services. A person’s protected request date for any OCDD waiver is the date of the first face–to-face interview in which he/she applied for waiver services and is determined eligible for developmental disabilities services by the entry unit. The order of entry into an OCDD

waiver is needs based from the registry arranged by an urgency of need assessment and date of application for developmentally disabled (DD) waiver services.

B. Funded OCDD waiver opportunities shall be offered based on the following priority groups:

1. individuals living at a publicly operated ICF-IDD or who lived at a publicly operated ICF-IDD when it was transitioned to a private ICF-IDD through a cooperative endeavor agreement (CEA facility), or their alternates. Alternates are defined as individuals living in a private ICF-IDD who will give up the private ICF-IDD bed to an individual living at a publicly operated ICF-IDD when it transitioned to a private ICF-IDD through a cooperative endeavor agreement (CEA Facility). Individuals requesting to transition from a publicly operated ICF-IDD are awarded a slot when one is requested, and their health and safety can be assured in an OCDD waiver. This also applies to individuals who were residing in a publicly operated facility at the time the facility was privatized and became a CEA facility. The funded waiver opportunity will be reserved for a period not to exceed 120 days; however, this 120-day period may be extended as needed.

2. individuals on the registry who have a current unmet need as defined by a screening for urgency of need (SUN) score of (three) urgent or (four) emergent and the earliest

registry date shall be notified in writing when a funded OCDD waiver opportunity is available.

C. The Office for Citizens with Developmental Disabilities has the responsibility to monitor the utilization of NOW opportunities. At the discretion of the OCDD, specifically allocated waiver opportunities may be reallocated, to better meet the needs of citizens with developmental disabilities in the state of Louisiana.

1. – 2. Repealed.

D. Funded waiver opportunities will only be allocated to individuals who successfully complete the financial and medical eligibility process required for waiver certification.

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, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 31:2900 (November 2005), amended LR 33:2440 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 37:3526 (December 2011), LR 40:70 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and

the Office for Citizens with Developmental Disabilities, LR 43:2529 (December 2017), LR 48:

**Chapter 139. Covered Services**

**§13901. Individual and Family Support Services**

A. Individual family support (IFS) services are direct support and assistance services, provided in the beneficiary's home or in the community, that allow the beneficiary to achieve and/or maintain increased independence, productivity, enhanced family functioning and inclusion in the community to the same degree as individuals without disabilities. IFS services are also used to provide relief to the primary caregiver. Transportation is included in the reimbursement for these services. Reimbursement for these services includes the development of a service plan for the provision of these services, based on the approved COPC.

1. Individual and family support day (IFS-D) services will be authorized during waking hours for up to 16 hours when natural supports are unavailable in order to provide continuity of services to the beneficiary. Waking hours are the period of time when the beneficiary is awake and not limited to traditional daytime hours as outlined in the CPOC.

a. ...

2. Individual family support-night (IFS-N) service is direct support and assistance provided during the

beneficiary’s sleeping “night” hours. Night hours are considered to be the period of time when the beneficiary is asleep and there is a reduced frequency and intensity of required assistance. IFS-N services are not limited to traditional nighttime hours and are outlined in the CPOC. The IFS-N worker must be immediately available and in the same residence as the beneficiary to be able to respond to the beneficiary’s immediate needs. Documentation of the level of support needed, based on the frequency and intensity of needs, shall be included in the CPOC with supporting documentation in the provider’s services plan. Supporting documentation shall outline the beneficiary’s safety, communication, and response methodology planned for and agreed to by the beneficiary and/or his/her authorized representative identified in his/her circle of support. The IFS-N worker is expected to remain awake and alert unless otherwise authorized under the procedures noted below.

a. Beneficiaries who are able during sleeping hours to notify direct support workers of his/her need for assistance may choose the option of IFS-N services where staff is not required to remain awake.

b. The beneficiary’s support team shall assess the beneficiary’s ability to awaken staff. If it is determined that the beneficiary is able to awaken staff and requests that

the IFS-N worker be allowed to sleep, the CPOC shall reflect the beneficiary's request.

c. Support teams should consider the use of technological devices that would enable the beneficiary to notify/awaken IFS-N staff. (Examples of devices include wireless pagers, alerting devices such as a buzzer, a bell or a monitoring system.) If the method of awakening the IFS-N worker utilizes technological device(s), the service provider will document competency in use of devices by both the beneficiary and IFS-N staff prior to implementation. The support coordinator will require a demonstration of effectiveness of this service no less than quarterly.

d. A review shall include review of log notes indicating instances when IFS-N staff was awakened to attend to the beneficiary. Also included in the review is acknowledgement by the beneficiary that IFS-N staff responded to his/her need for assistance timely and appropriately. Instances when staff did not respond appropriately will immediately be brought to the support team for discontinuation of allowance of the staff to sleep. The service will continue to be provided by awake and alert staff.

e. ...

B. IFS services may be shared by up to three waiver beneficiaries who may or may not live together and who have a

common direct service provider agency. Waiver beneficiaries may share IFS services staff when agreed to by the beneficiaries and health and welfare can be assured for each beneficiary. The decision to share staff must be reflected on the CPOC and based on an individual-by-individual determination and choice. Reimbursement rates are adjusted accordingly. Shared IFS services, hereafter referred to as shared support services, may be either day or night services. In addition, IFS direct support may be shared across the Children's Choice Waiver or the Residential Options Waiver at the same time.

C. IFS (day or night) services include:

C.1. – C.5. ...

6. accompanying the beneficiary to the hospital and remaining until admission or a responsible representative arrives, whichever occurs first. IFS services may resume at the time of discharge.

D. Exclusions. The following exclusions apply to IFS services.

1. IFS-D services and IFS-N services will not be authorized or provided to the beneficiary while the beneficiary is in a center-based respite facility.

2. IFS-D and IFS-N services will not be authorized or provided to the beneficiary while the beneficiary is receiving monitored in-home caregiving services.

3. Beneficiaries receiving adult companion care services are not eligible to receive individual family support services.

E. Staffing Criteria and Limitations

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

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

3. Repealed.

F. – G ...

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 30:1202 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:2063

(November 2006), LR 33:1647 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:71 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:51 (January 2018), LR 48:

**§13902 Individual and Family Support Supplemental Payments**

A. – B.2.b.ii. ...

C. The supplemental payment is not allowed for waiver beneficiaries who do not receive individual and family support (IFS) services.

D. The supplemental payment may not be approved for waiver beneficiaries receiving IFS hours in addition to 12 or more hours of skilled nursing per day.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:1681 (December 2020), LR 48:

**§13903. Center-Based Respite Care**

A. Center-based respite (CBR) care is temporary, short-term care provided to a beneficiary with developmental

disabilities who requires support and/or supervision in his/her day-to-day life due to the absence or relief of the primary caregiver. While receiving center-based respite care, the beneficiary's routine is maintained in order to attend school, work or other community activities/outings. The respite center is responsible for providing transportation for community outings, as that is included as part of its reimbursement.

B. Exclusions

1. Individual family support services (both day and night) may not be provided and will not be reimbursed while the beneficiary is in a center–based respite facility.

2. Monitored in home caregiving, adult companion care, and supported independent living services cannot be reimbursed while the beneficiary is in a center-based respite facility.

3. The cost of room and board cannot be claimed except when provided as part of respite care furnished in a facility approved by the state that is not a private residence.

C. Service Limits. CBR services shall not exceed 720 hours per beneficiary, per CPOC year.

1. Beneficiaries may request approval of hours in excess of 720 hours. The request must be submitted to the OCDD central office with proper justification and documentation for prior approval.

D. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1203 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1648 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:72 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:51 (January 2018), LR 48:

**§13905. Community Life Engagement Development**

A. Community life engagement development (CLE) facilitates the development of opportunities to assist beneficiaries in becoming involved in the community through the creation of natural supports. The purpose of CLE is to encourage and foster the development of meaningful relationships in the community reflecting the beneficiary’s choices and values. Objectives outlined in the comprehensive plan of care will afford opportunities to increase community inclusion, participation in leisure/recreational activities, and encourage

participation in volunteer and civic activities. Reimbursement for this service includes the development of a service plan. To utilize this service, the beneficiary may or may not be present as identified in the approved CLE service plan. CLE services may be performed by a shared supports worker for up to three waiver beneficiaries who have a common direct service provider agency. Rates shall be adjusted accordingly.

B. Transportation costs are included in the reimbursement for CLE services.

C. Service Limitations. Services shall not exceed 60 hours per beneficiary per CPOC year which includes the combination of shared and non-shared community integration development.

D. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1203 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1648 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:72 (January

2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:52 (January 2018), LR 48:

**§13907. Supported Independent Living**

A. Supported independent living (SIL) assists the beneficiary to acquire, improve or maintain those social and adaptive skills necessary to enable a beneficiary to reside in the community and to participate as independently as possible. SIL services include assistance and/or training in the performance of tasks such as personal grooming, housekeeping and money management. Payment for this service includes oversight and administration and the development of service plans for the enhancement of socialization with age-appropriate activities that provide enrichment and may promote wellness. The service plan should include initial, introduction, and exploration for positive outcomes for the beneficiary for community integration and development. These services also assist the beneficiary in obtaining financial aid, housing, advocacy and self-advocacy training as appropriate, emergency support, trained staff and assisting the beneficiary in accessing other programs for which he/she qualifies. SIL beneficiaries must be 18 years or older.

B. Place of Service. Services are provided in the beneficiary’s residence and/or in the community. The beneficiary’s residence includes his/her apartment or house,

provided that he/she does not live in the residence of any legally responsible relative. An exception will be considered when the beneficiary lives in the residence of a spouse or disabled parent, or a parent aged 70 years or older. Family members who are not legally responsible relatives can be SIL workers provided they meet the same qualifications as any other SIL worker. A legally responsible relative is defined as a parent of a minor child, foster parent, curator, tutor, legal guardian, or the beneficiary's spouse.

C. Exclusions

1. ...

2. SIL shall not include the cost of:

a. – b. ...

c. home maintenance, or upkeep, improvement, modifications, or adaption to a home, or to meet the requirements of the applicable life safety code;

2.d. – 3. ...

4. Beneficiaries receiving adult companion care services are not eligible to receive supported independent living services.

5. Monitored in-home-caregiving services cannot be provided at the same time or on the same day as supported independent living.

D. Service Limit. SIL services are limited to one service per day, per CPOC year, except when the beneficiary is in center-based respite. When a beneficiary living in an SIL setting is admitted to a center-based respite facility, the SIL provider shall not bill the SIL per diem beginning with the date of admission to the center-based respite facility and through the date of discharge from the center-based respite facility.

E. ...

F. Provider Responsibilities

1. Minimum direct services by the SIL agency include two documented contacts per week and one documented face-to-face contact per month by the SIL provider agency in addition to the approved direct support hours. These required contacts must be completed by the SIL agency supervisor so designated by the provider agency due to the experience and expertise relating to the beneficiary's needs or a licensed/certified professional qualified in the state of Louisiana who meets requirements as defined by 42 CFR §483.430 or any subsequent regulation.

2. – 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 Community Supports and Services, LR 30:1204 (June 2004), amended by the

Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1648 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:73 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:52 (January 2018), LR 48:

**§13909. Substitute Family Care**

A. Substitute family care (SFC) provides for day programming, transportation, independent living training, community integration, homemaker, chore, attendant care and companion services, and medication oversight (to the extent permitted under state law) to beneficiaries residing in a substitute family care home that meets all licensing requirements for the substitute family care module. The service is a stand-alone family living arrangement for beneficiaries aged 18 years and older. The SFC house parents assume the direct responsibility for the beneficiary’s physical, social, and emotional well-being and growth, including family ties. Only two SFC beneficiaries may reside in a single SFC setting at the same time. There shall be no more than three persons living in a substitute family care setting who are unrelated to the SFC provider. Immediate family members (mother, father, brother

and/or sister) cannot be substitute family care parents. Reimbursement for this service includes the development of a service plan based on the approved CPOC. Beneficiaries living in an SFC home may receive IFS services.

B. ...

C. Exclusions

1. Beneficiaries receiving adult companion care services are not eligible to receive substitute family care services.

2. Payments may not be made for room and board, items of comfort or convenience, or the cost of facility maintenance, upkeep, or improvement.

3. Payments may not be made directly or indirectly to members of the beneficiary’s immediate family.

D. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1204 (June 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:73 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office

for Citizens with Developmental Disabilities, LR 44:52 (January 2018), LR 48:

**§13911. Day Habilitation**

A. Day habilitation is provided in a community-based setting and provides the beneficiary assistance with social and adaptive skills necessary to enable the beneficiary to participate as independently as possible in the community. These services focus on socialization with meaningful age-appropriate activities which provide enrichment and promote wellness, as indicated in the beneficiary's CPOC. Day habilitation services are provided in a variety of community settings, (i.e. local recreation department, garden clubs, libraries, etc.) other than the person's residence, except for virtual habilitation services, and are not limited to a fixed-site facility.

1. Day habilitation services must be directed by a person-centered service plan and provide the beneficiary choice in how they spend their day. The activities should assist the beneficiary to gain their desired community living experience, including the acquisition, retention or improvement in self-help, socialization and adaptive skills, and/or to provide the individual an opportunity to contribute to and be a part of his or her community.

2. Day habilitation services shall be coordinated with any therapy, prevocational service, or supported employment

models that the beneficiary may be receiving. The beneficiary does not receive payment for the activities in which he/she are engaged. The beneficiary must be 18 years of age or older in order to receive day habilitation services.

3. Career planning activities may be a component of the beneficiary's plan and may be used to develop learning opportunities and career options consistent with the person's skills and interests.

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

1. onsite day habilitation

2. community life engagement

3. virtual day habilitation

C. Day Habilitation is provided on a regularly scheduled basis and may be scheduled on a plan of care for one or more days per week and may be prior authorized for up to 8,320 units of service in a plan of care year. A standard unit of service is a 15-minute increment.

D. Licensing Requirements. Providers must be licensed by the Department of Health and as a home and community-based services provider and must meet the module specific requirements for the service being provided.

E. Service Limitations

1. Beneficiaries receiving day habilitation services may also receive prevocational or supported employment services, but these services cannot be provided the same time period.

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

3. Community life engagement cannot be delivered at the same time as any other service.

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 30:1204 (June 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:73 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:53 (January 2018), LR 48:

**§13913. Supported Employment**

A. Supported employment is competitive work in an integrated work setting, or employment in an integrated work setting in which the beneficiaries are working toward competitive work that is consistent with the strengths, resources, priorities, interests, and informed choice of

beneficiaries for whom competitive employment has not traditionally occurred. The beneficiary must be eligible and assessed to need the service in order to receive supported employment services. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which an individual is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

B. ...

C. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment cannot be provided at worksites that are facility based, or other similar types of vocational services furnished in specialized facilities that are not part of the general workplace. Supported employment includes activities needed by waiver beneficiaries to sustain paid work, including supervision and training and is based on an individualized service plan. Supported employment may include assistance and prompting with:

1. – 8. ...

D. Supported Employment Models. Reimbursement for supported employment includes an individualized service plan for each model.

1. Individual supported employment one-to-one services include all aspects of the supported employment, process including assessments, development, placement, job retention, and stabilization that are necessary to get an individual to work in an individual competitive job in the community.

2. Follow-along support services provide ongoing supports to individuals and their employers who need the support to maintain their job in integrated work settings in the general workforce. The amount of support is determined for each individual based on the individual’s ability to be independent in the job. Follow-along services may be delivered virtually.

3. Group employment is an employment setting in which a group of two to eight beneficiaries work to complete jobs in a variety of locations in the community under the supervision of an employment specialist in a manner that promotes integration into the workplace and interaction between beneficiaries and people without disabilities in those workplaces that are in the community.

E. Service Exclusions

1. Supported employment services shall not be used in conjunction or simultaneously with any other waiver service, except substitute family care, supported independent living, and skilled nursing services. Virtual follow-along supported employment services cannot be utilized at the same time as any other service.

2. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by beneficiaries receiving waiver services as a result of his/her disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

3. Supported employment services are not available to beneficiaries who are eligible to participate in programs funded under section 110 of the Rehabilitation Act of 1973 or sections 602(16) and (17) of the Individuals with Disabilities Education Act [20 U.S.C. 1401(26) and (29), as amended, and those covered under the Medicaid State Plan, if applicable.

F. Service Limits

1. Individual supported employment one-to-one services shall not exceed 2,880 one-quarter hour units (15 minute increments)per CPOC year.

2. Both individual and virtual supported employment follow-along services shall not exceed 960 one-quarter hour units (15 minute increments) per CPOC year.

3. Group supported employment services shall not exceed 8,320 one-quarter hour units of service per CPOC year, without additional documentation and approval..

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

G. ...

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 30:1205 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:74 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:53 (January 2018), LR 48:

**§13915. Transportation for Day Habilitation and Supported Employment Models**

A. Transportation provided for the beneficiary to the site of the day habilitation or supported employment model, or between the day habilitation and supported employment model site (if the beneficiary receives services in more than one place) is reimbursable when day habilitation or supported employment model has been provided. Reimbursement may be made for a one-way trip. There is a maximum fee per day that can be charged for transportation regardless of the number of trips per day.

1. Transportation is included in the group supported employment service rate when traveling between job sites.

2. Transportation is a separate billable service if criteria is met. One rate covers regular transportation, and a separate rate covers wheelchair transportation.

3. Transportation may be provided to and/or from the beneficiary’s residence or a location agreed upon by the beneficiary or authorized representative to the onsite location or community location and a separate return trip.

B. Licensing Requirements. Providers must be licensed by the Department of Health as a home and community- based services provider and meet the module specific requirements for the service being provided. The provider must have insurance coverage on any vehicles used in transporting a beneficiary that meets current home and community-based services providers licensing standards.

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 30:1205 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:2064 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:74 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:54 (January 2018), LR 48:

**§13917. Prevocational Services**

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

1. – 2. Repealed.

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

1. onsite prevocational services

2. community career planning

3. virtual prevocational services

C. Prevocational services are to be provided in a variety of locations in the community and are not to be limited to a fixed site facility. Activities associated with prevocational services should focus on preparing the beneficiary for integrated individual employment in the community. These services are operated through a provider agency that is licensed by the appropriate state licensing agency. Beneficiaries receiving prevocational services must participate in activities designed to establish an employment related goal as part their CPOC. Prevocational services are designed to help create a path to integrated community-based employment for which a beneficiary is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

1. Repealed.

D. Prevocational services are provided on a regularly scheduled basis and may be scheduled on a comprehensive plan of

care for one or more days per week and may be prior authorized for up to 8,320 units of service in a plan year with appropriate documentation. A standard unit is one-quarter hour (15 minute increment).

E. Exclusions. The following service exclusions apply to prevocational services.

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

2. Prevocational services cannot be provided or billed during the same hours on the same day as other services.

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

4. Transportation is billed as a separate service.

F. Service Limits

1. Prevocational services cannot exceed 8,320 one-quarter hour units of service per CPOC year.

2. On-site prevocational and community career planning services are time limited and individually based with employment at the individual’s highest level of work in the most integrated setting in the community while following applicable

federal wage guidelines. Beneficiaries may choose to leave this service at any time or seek employment at any time.

3. Through permission from the local governing entity, a person may complete this service more than once.

G. Licensing Requirements. Providers must be licensed by the Department of Health as a home and community-based services provider and must meet the module specific requirements for the service being provided.

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 30:1205 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:75 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:55 (January 2018), LR 48:

**§13919. Environmental Accessibility Adaptations**

A. Environmental accessibility adaptations are physical adaptations to the home or a vehicle that are necessary to

ensure the health, welfare, and safety of the beneficiary or that enable him/her to function with greater independence in the home and/or community. Without these services, the beneficiary would require additional supports or institutionalization.

B. Such adaptations may include:

1. – 3. ...

4. installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies for the welfare of the beneficiary; or

5. adaptations to the vehicle, which may include a lift or other adaptations, to make the vehicle accessible to the beneficiary or for the beneficiary to drive.

C. ...

1. Any service covered under the Medicaid state plan shall not be authorized by NOW. The environmental accessibility adaptation(s) must be delivered, installed, operational and accepted by the beneficiary/authorized representative in the CPOC year for which it was approved. The environmental accessibility adaptation(s) must be billed and reimbursed according to the Medicaid billing guidelines established by LDH policy. A written itemized detailed bid, including drawings with the dimensions of the existing and proposed floor plans relating to the modification, must be obtained and submitted for prior authorization. Modifications may be applied to rental or leased

property with the written approval of the landlord and approval of the human services authority or district. Reimbursement shall not be paid until receipt of written documentation that the job has been completed to the satisfaction of the beneficiary.

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

3. Excluded are those adaptations or improvements to the residence that are of general utility or maintenance and are not of direct medical or remedial benefit to the beneficiary, including, but not limited to:

a. air conditioning or heating;

b. flooring;

c. roofing, installation or repairs;

d. smoke and carbon monoxide detectors, sprinklers, fire extinguishers, or hose; or

e. furniture or appliances; or

f. whole home generators.

4. ...

5. Home modification funds are not intended to cover basic construction cost. For example, funds may be used to cover the difference between constructing a bathroom and building an

accessible or modified bathroom, but in any situation funds must be used to pay for a specific approved adaptation.

6. ...

D. Service Limits. There is a cap of $7,000 per three-year period for a beneficiary for environmental accessibility adaptations. On a case-by-case basis, with supporting documentation and based on need, a beneficiary may be able to exceed this cap with the prior approval of OCDD central office.

E. – E.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, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1206 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:75 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:55 (January 2018), LR 48:

**§13921. Specialized Medical Equipment and Supplies**

A. Specialized medical equipment and supplies (SMES) are devices, controls, or appliances which enable the beneficiary to:

1. – 3. ...

B. The service includes medically necessary durable and nondurable medical equipment not covered under the Medicaid state plan. NOW does not cover non-medically necessary items. All items shall meet applicable standards of manufacture, design and installation. Routine maintenance or repair of specialized medical equipment is funded under this service.

C. All alternate funding sources that are available to the beneficiary shall be pursued before a request for the purchase or lease of specialized equipment and supplies will be considered.

D. Exclusion. Excluded are specialized equipment and supplies that are of general utility or maintenance, but are not of direct medical or remedial benefit to the beneficiary. Excluded also are those durable and non-durable items that are available under the Medicaid State Plan.

E. Service Limitations. There is a cap of $1,000 per three year period for a beneficiary for specialized equipment and supplies. On a case-by-case basis, with supporting documentation and based on need, a beneficiary may be able to exceed this cap with the prior approval of OCDD central office.

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 Community Supports and Services, LR 30:1207 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:75 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:56 (January 2018), LR 48:

**§13923. Personal Emergency Response Systems**

A. Personal emergency response systems (PERS) is a rented electronic device connected to the person's phone and programmed to signal a response center which enables a beneficiary to secure help in an emergency.

B. Beneficiary Qualifications. Personal emergency response systems (PERS) services are available to those persons who:

1. – 3. ...

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

D. ...

E. Provider Qualifications. The provider must be an enrolled Medicaid provider of the PERS. The provider shall install and support PERS equipment in compliance with all applicable federal, state, parish and local laws and meet manufacturer's specifications, response requirements, maintenance records and beneficiary education.

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 30:1207 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1650 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:76 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:

**§13925. Professional Services**

A. Professional services are services designed to increase the beneficiary’s independence, participation and productivity in the home, work and community. Beneficiaries, up to the age of 21, who participate in NOW must access these services through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Professional services may only be furnished and reimbursed through NOW when the services are not covered under the Medicaid State Plan. Professional services must be delivered with the beneficiary present and be provided based on the approved CPOC and an individualized service plan. Service intensity, frequency and duration will be determined by individual need. Professional services may be utilized to:

1. – 2. ...

3. provide training or therapy to a beneficiary and/or his/her natural and formal supports necessary to either develop critical skills that may be self-managed by the beneficiary or maintained according to the beneficiary’s needs;

4. ...

5. provide necessary information to the beneficiary, family, caregivers and/or team to assist in the implementation of plans according to the approved CPOC.

B. Professional services are limited to the following services.

1. Psychological services are direct services performed by a licensed psychologist, as specified by state law and licensure. These services are for the treatment of a behavioral or mental condition that addresses personal outcomes and goals desired by the  and his/her team. Services must be reasonable and necessary to preserve and improve or maintain adaptive behaviors or decrease maladaptive behaviors of a person with developmental disabilities. Service intensity, frequency, and duration will be determined by individual need.

2. – 3. ...

C. Service Limits. There shall be a $2,250 cap per beneficiary per CPOC year for the combined range of professional services in the same day but not at the same time. Additional services may be prior authorized if the beneficiary reaches the cap before the expiration of the comprehensive plan of care and the beneficiary’s health and safety are at risk. One or more professional services may be utilized in the same day, but not at the same time.

D. – E.5. ...

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 30:1207 (June 2004), amended by the

Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1650 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:76 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:56 (January 2018), LR 48:

**§13927. Skilled Nursing Services**

A. Skilled nursing services are medically necessary nursing services ordered by a physician and provided by a licensed registered nurse, nurse practitioner, or a licensed practical nurse working under the supervision of a registered nurse. Skilled nursing services shall be provided by a licensed, enrolled home health agency and require an individual nursing service plan. These services must be included in the beneficiary’s approved CPOC. All available Medicaid State Plan skilled nursing services must be exhausted before accessing this service. Beneficiaries, up to the age of 21, must access these services as outlined on the CPOC through the Home Health Program in the Medicaid State Plan pursuant to the EPSDT benefit.

B. When there is more than one beneficiary in the home receiving skilled nursing services, services may be shared and payment must be coordinated with the service authorization

system and each beneficiary approved CPOC. Nursing consultations are offered on an individual basis only.

C. ...

D. Monitored in-home caregiving services cannot be provided at the same time or on the same day as skilled nursing services.

E. All requests for over 12 hours of skilled nursing per day must be reviewed and approved by the LDH medical director and medical evaluation team.

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 30:1208 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1651 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:77 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:56 (January 2018), LR 46:1681 (December 2020), LR 48:

**§13929. One-Time Transitional Expenses**

A. One-time transitional expenses are those allowable one-time, set-up expenses incurred by beneficiaries who are being transitioned from an ICF-DD to his/her own home or apartment of their choice in the community of their choice. *Own home* shall mean the beneficiary's own place of residence and does not include any family members' home or substitute family care homes. The beneficiaries must be allowed choice in the items purchased.

B. Allowable transitional expenses include:

1. the purchase of essential furnishings, such as:

a. bedroom and living room furniture,

b. dining table and chairs,

c. window blinds,

d. eating utensils, and

e. ...

2. – 3. ...

4. non-refundable security deposits required to obtain a lease on an apartment or home and set-up fees for utilities.

C. Service Limits. Set-up expenses are capped at $3,000 over a beneficiary's lifetime.

D. – 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, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1208 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1651 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:77 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:56 (January 2018), LR 48:

**§13931. Adult Companion Care**

A. Adult companion care services assist the beneficiary to achieve and/or maintain the outcomes of increased independence, productivity and inclusion in the community. These services are designed for an individual who lives independently and can manage his/her own household with limited supports. The companion is a principal care provider chosen by the beneficiary, who provides services in the beneficiary’s home. The companion must be at least 18 years of age and lives with the beneficiary as a roommate. Adult companion care services are furnished through a licensed provider organization as outlined in the beneficiary’s CPOC. This service includes:

1. providing assistance with all of the activities of daily living as indicated in the beneficiary’s CPOC;

2. – 3. ...

B. Adult companion care services are arranged by provider organizations that are subject to licensure. The setting is the beneficiary’s home which should have been freely chosen by the beneficiary from among non-disability specific settings and not owned or controlled by the provider. The companion is an employee or contractor of the provider organization and is responsible for providing limited, daily direct services to the beneficiary.

1. ...

2. Services may not be provided by a family member who is a legally responsible individual, such as the beneficiary’s spouse, or a legal guardian.

C. Provider Responsibilities

1. The provider organization shall develop a written agreement as part of the beneficiary CPOC which defines all of the shared responsibilities between the companion and the beneficiary. The written agreement shall include, but is not limited to:

a. – c. ...

2. Repealed.

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

a. ...

b. making an initial home visit to the beneficiary home, as well as periodic home visits as required by the department;

c. contacting the companion a minimum of once per week or as specified in the beneficiary’s comprehensive plan of care; and

d. ...

4. The provider shall facilitate a signed written agreement between the companion and the beneficiary which assures that:

a. ...

b. inclusion of any other expenses must be negotiated between the beneficiary and the companion. These negotiations must be facilitated by the provider and the resulting agreement must be included in the written agreement and in the beneficiary’s CPOC.

D. Companion Responsibilities

1. – 1.c. ...

2. The companion is an employee of the provider agency and is paid a flat daily rate to provide adult companion care services as included in the approved CPOC.

3. The companion is responsible for meeting all financial obligations as agreed upon in the agreement between the provider agency, the beneficiary, and the companion.

E. Service Limits

1. Adult companion care services may be authorized for up to 365 days per year as documented in the beneficiary's CPOC.

F. Service Exclusions

1. Adult companion care services cannot be provided or billed for at the same time as center-based respite care services.

2. Beneficiaries receiving adult companion care services are not eligible for receiving the following services:

a. – b. ...

c. substitute family care;

d. skilled nursing; or

e. monitored in-home caregiving (MIHC)

G. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:77 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:57 (January 2018), repromulgated LR 44:282 (February 2018), LR 48:

**§13935. Housing Stabilization Transition Service**

A. Housing stabilization transition service enables beneficiaries who are transitioning into a permanent supportive housing unit, including those transitioning from institutions, to secure their own housing. The service is provided while the beneficiary is in an institution and preparing to exit the institution using the waiver. The setting for the permanent supportive housing must be integrated in the greater community, and support full access to the greater community by the beneficiary. The service includes the following components:

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

a. access to housing of the beneficiary’s choice, including non-disability specific settings;

b. – h. ...

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

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

a. ...

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

A.3.c. – B. ...

C. Beneficiaries may not exceed 165 combined units of this service and the housing stabilization service.

1. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:78 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:57 (January 2018), LR 48:

**§13937. Housing Stabilization Service**

A. Housing stabilization service enables waiver beneficiaries to maintain their own housing as set forth in the beneficiary's approved CPOC. Services must be provided in the home or a community setting. This service includes the following components:

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

a. – h. ...

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

3. developing an individualized housing stabilization service provider plan based upon the housing assessment that includes short and long-term measurable goals for each issue, establishes the beneficiary's approach to meeting the goal, and identifies where other provider(s) or services may be required to meet the goal. This includes updating the housing support plan annually or as needed due to changes in the beneficiary's situation or status;

4. participating in the development of the CPOC, incorporating elements of the housing stabilization service provider plan. This includes participation in plan of care renewals and updates as needed;

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

6. providing ongoing communication with the landlord or property manager regarding the beneficiary's disability, accommodations needed, and components of emergency procedures involving the landlord or property manager; and

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

B. This service is only available upon referral from the support coordinator and the service is not duplicative of other waiver services including support coordination. It is only available to persons who are residing in a state of Louisiana

permanent supportive housing unit or who are linked for a state of Louisiana permanent supportive housing unit.

C. Beneficiaries may not exceed 165 combined units of this service and the housing stabilization transition service.

1. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:79 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:57 (January 2018), LR 48:

**§13939. Monitored In-Home Caregiving Services**

A. Monitored in-home caregiving (MIHC) services are provided by a principal caregiver to a beneficiary who lives in a private unlicensed residence.

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

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

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

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

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

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

4. supervision or assistance with health related tasks, meaning any health related procedures governed under the Nurse Practice Act, in accordance with applicable laws governing the delegation of medical tasks/medication administration.

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

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

C. Service Exclusions and Restrictions

1. Beneficiaries electing monitored in-home caregiving are not eligible to receive the following New Opportunities Waiver services during the period of time that the beneficiary is receiving monitored in-home caregiving services:

a. individual family support;

b. center-based respite;

c. supported independent living;

d. adult companion care; or

e. skilled nursing care;

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

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

2. The agency provider will pay per diem stipends to caregivers. The per diem for monitored in-home caregiving services does not include payments for room and board.

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

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

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

F. The department shall reimburse for monitored in-home caregiving services based on a two-tiered model which is designed to address the beneficiary’s acuity. Reimbursement will not be made for room and board of the principal caregiver, and federal financial participation is not available for room and board.

G. Provider Qualifications

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

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

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

4. The principal caregiver must:

a. be at least 18 years of age;

b. live in the home with the beneficiary; and

c. be available 24 hours a day, 7 days a week.

H. The assessment performed by the monitored in-home caregiving provider shall be reimbursed when the service has been approved by the plan of care.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:

**§13941. Dental Services**

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

1. adult diagnostic services;

2. preventative services;

3. restorative services;

4. endodontics;

5. periodontics;

6. prosthodontics;

7. oral and maxillofacial surgery;

8. orthodontics;

9. emergency care; and

10. adjunctive general services

B. Dental Service Exclusions

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

2. Non-covered services include but are not limited to the following:

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

b. dental care for cosmetic reasons;

c. experimental procedures;

d. plaque control;

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

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

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

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

i. dental expenses related to any dental services:

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

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

j. administration of in-office pre-medication.

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

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:

## Chapter 141. Self-Direction Initiative

### §14101. Self-Direction Service Delivery Option

A. The self-direction initiative is a voluntary, self-determination option which allows the beneficiary to coordinate the delivery of NOW services, as designated by OCDD, through an

individual direct support professional rather than through a licensed, enrolled provider agency. Selection of this option requires that the beneficiary utilize a payment mechanism approved by the department to manage the required fiscal functions that are usually handled by a provider agency.

B. Beneficiary Responsibilities. Waiver beneficiaries choosing the self-directed service delivery option must understand the rights, risks and responsibilities of managing his/her own care and individual budget. If the beneficiary is unable to make decisions independently, he/she must have an authorized representative who understands the rights, risks and responsibilities of managing his/her care and supports within his/her individual budget. Responsibilities of the beneficiary or authorized representative include:

1. – 2. ...

3. participation in the development and management of the approved personal purchasing plan:

a. this annual budget is determined by the recommended service hours listed in the beneficiary’s CPOC to meet his/her needs;

b. the beneficiary’s individual budget includes a potential amount of dollars within which the beneficiary or his/her authorized representative exercises decision-making

responsibility concerning the selection of services and service providers.

C. ...

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

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

a. the health or welfare of the beneficiary is compromised by continued participation in the self-direction service delivery option;

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

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

d. over three consecutive payment cycles, the beneficiary or authorized representative:

C.2.d.i. – D. ...

E. All services must be documented in service notes, which describes the services rendered and progress towards the

beneficiary’s personal outcomes and his/her comprehensive plan of care.

F. Service Limits

1. Authorized representatives, legally responsible individuals, and legal guardians may be the employers in the self-directed option but may not also be the employees.

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

3. Family members who are employed in the self-directed option must meet the same standards as direct support staff that are not related to the beneficiary.

4. Family members who live in the home with the beneficiary cannot exceed a total of 40 hours per week when employed in the self-directed option.

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 of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1651 (August 2007), amended by the Department of Health and

Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:79 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:58 (January 2018) LR 48:

**Chapter 142. Provider Participation Requirements**

**§14202. Incident Reporting, Tracking and Follow-Up**

A. The direct service provider is responsible for responding to, reviewing, and remediating incidents that occur to the beneficiaries they support. Direct service providers must comply with any other rules promulgated by the LDH regarding incident reporting and response.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:58 (January 2018), amended LR 48:

**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 beneficiary. 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 beneficiaries may choose to share community integration development if they share a common provider of this service;

2.b. – 4. ...

5. individual and family support-day and night:

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

5.b. – 6. ...

7. skilled nursing services:

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

b. – c. ...

8. supported employment;

9. – 10. ...

B. The following services are to be paid at cost, based on the need of the beneficiary and when the service has been prior authorized and on the CPOC:

1. – 3. ...

C. The following services are paid through a per diem:

1. – 2. ...

3. adult companion care;

4. individual and family support supplemental payments; and

5. monitored in-home caregiving services.

D. – F.4.a. ...

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

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), LR 36:1247 (June 2010), LR 37:2158 (July 2011), LR 39:1049 (April 2013), LR 40:80 (January 2014), LR 42:898 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR

44:58 (January 2018), LR 45:44 (January 2019), LR 46:1682 (December 2020), LR 48:41 (January 2022), LR 48:

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.

**Family Impact Statement**

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 a positive impact on family functioning, stability and autonomy as described in R.S. 49:972, since assures access to dental services and additional care options for New Opportunities Waiver beneficiaries.

**Poverty Impact Statement**

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 a positive impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973 as it assures access to dental services and additional care options for New Opportunities Waiver beneficiaries.

## Small Business Analysis

In compliance with the Small Business Protection Act, the economic impact of this proposed Rule on small businesses has been considered. It is anticipated that this proposed Rule may have a positive impact on small businesses, as described in R.S. 49:978.1 et seq. since it provides reimbursement for services that were not previously covered.

## Provider Impact Statement

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, but may reduce the total direct and indirect cost to the provider to provide the same level of service, and may enhance the provider's ability to provide the same level of service as described in HCR 170 since this proposed Rule provides reimbursement for services that were not previously covered.

## Public Comments

Interested persons may submit written comments to Patrick Gillies, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821–9030. Mr. Gillies is responsible for responding to inquiries regarding this proposed Rule. The

deadline for submitting written comments is at 4:30 p.m. on April 29, 2022.

**Public Hearing**

Interested persons may submit a written request to conduct a public hearing by U.S. mail to the Office of the Secretary ATTN: LDH Rulemaking Coordinator, Post Office Box 629, Baton Rouge, LA 70821-0629; however, such request must be received no later than 4:30 p.m. on April 11, 2022. If the criteria set forth in R.S. 49:953(A)(2)(a) are satisfied, LDH will conduct a public hearing at 9:30 a.m. on April 28, 2022 in Room 118 of the Bienville Building, which is located at 628 North Fourth Street, Baton Rouge, LA. To confirm whether or not a public hearing will be held, interested persons should first call Allen Enger at (225) 342-1342 after April 11, 2022. If a public hearing is to be held, all interested persons are invited to attend and present data, views, comments, or arguments, orally or in writing. In the event of a hearing, parking is available to the public in the Galvez Parking Garage, which is located between North Sixth and North Fifth/North and Main Streets (cater-corner from the Bienville Building). Validated parking for the Galvez Garage may be available to public hearing attendees when the parking ticket is presented to LDH staff at the hearing.

Dr. Courtney N. Phillips

Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT**
**FOR ADMINISTRATIVE RULES**

Person Preparing Statement: Veronica Dent

Phone: 342-3238

Return Address: PO Box 91030
Baton Rouge, LA

Dept.: Health

Office: Bureau of Health Services Financing

Rule Title: Home and Community-Based Services Waivers
New Opportunity Waiver
Dental Services

Date Rule Takes Effect: June 20, 2022

SUMMARY
(Use complete sentences)

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 STATEMENTS SUMMARIZE ATTACHED WORKSHEETS, I THROUGH IV AND 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 result in increased state costs of approximately $3,942 for FY 21-22, $3,489,816 for FY 22-23 and $3,489,029 for FY 23-24. It is anticipated that $7,884 ($3,942 SGF and $3,942 FED) will be expended in FY 21-22 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 increase statutory dedicated revenue collections by approximately $190,940 for FY 22-23 and $259,257 for FY 23-24 In addition, it is anticipated that the implementation of this proposed rule will increase federal revenue collections by approximately $3,942 for FY 21-22, $3,489,816 for FY 22-23, and $3,489,029 for FY 23-24. It is anticipated that $3,942 will be collected in FY 21-22 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, SMALL BUSINESSES, OR NON-GOVERNMENTAL GROUPS (Summary)

This proposed rule, in compliance with Act 450 of the 2021 Regular Session of the Louisiana Legislature amends the provisions governing the New Opportunities Waiver (NOW) in order to add adult dental services as a covered service. In addition, it also proposes to add waiver flexibilities in the delivery of NOW services under certain conditions including allowing family members as paid caregivers, the 16-hour rule and shared services. This proposed rule will benefit NOW beneficiaries by covering adult dental services and allowing flexibility in the delivery of services. Providers will benefit from implementation of this proposed rule as it is anticipated that it will increase payments for these services by approximately $11,314,958 for FY 22-23 and $11,522,553 for FY 23-24.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

Signature of Agency Head or Designee

Patrick Gillies, Medicaid Executive Director
Typed Name & Title of Agency Head or Designee

March 8, 2022
Date of Signature

Evan Brasseaux, Interim Deputy Fiscal Officer
Legislative Fiscal Officer or Designee

3/8/22
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 deliberation 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, in compliance with Act 450 of the 2021 Regular Session of the Louisiana Legislature, amends the provisions governing the New Opportunities Waiver (NOW) in order to add adult dental services as a covered service. In addition, it also proposes to add waiver flexibilities in the delivery of NOW services under certain conditions including allowing family members as paid caregivers, the 16-hour rule and shared services.

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

Act 450 of the 2021 Regular Session of the Louisiana Legislature directed the Department of Health to provide dental care to each person age 21 or older enrolled in any Medicaid waiver program for persons with developmental or intellectual disabilities. In compliance with Act 450, the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities propose to amend the provisions governing the New Opportunities Waiver in order to add adult dental services as a covered service. The department also proposes to amend the provisions governing delivery of services in the New Opportunities Waiver under certain conditions including allowing family members as paid caregivers, the 16-hour rule and shared services.

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.

Yes. It is anticipated that implementation of this proposed rule will result in increased programmatic costs of approximately $7,884 for FY 21-22, $11,314,958 for FY 22-23, and $11,522,553 for FY 23-24. In FY 21-22, $7,884 is included 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) _____ Yes. If yes, attach documentation.

(b) __X__ NO. If no, provide justification as to why this rule change should be published at this time

Act 119 of the 2021 Regular Session of the Louisiana Legislature allocated funds to the Medical Vendor Program for payments to providers and the operation of the Medicaid Program, and thereby, authorizes the expenditure of these funds. Implementation of this proposed rule will be beneficial to NOW beneficiaries by adding adult dental services and allowing flexibilities in delivery of waiver services.

**FISCAL AND ECONOMIC IMPACT STATEMENT**
**WORKSHEET**

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

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

| COSTS | FY 22 | FY 23 | FY 24 |
|---|---|---|---|
| Personal Services | | | |
| Operating Expenses | $0 | $0 | $0 |
| Professional Services | | | |
| Other Charges | $7,884 | $11,314,958 | $11,522,553 |
| Equipment | | | |
| Major Repairs & Constr. | | | |
| **TOTAL** | **$7,884** | **$11,314,958** | **$11,522,553** |
| **POSITIONS (#)** | | | |

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.

   The expenses reflected above are the estimated increases in expenditures in the Medicaid program. In FY 21-22, $7,884 is included 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 22 | FY 23 | FY 24 |
|---|---|---|---|
| State General Fund | $3,942 | $3,489,816 | $3,489,029 |
| Agency Self-Generated | | | |
| Dedicated | $0 | $190,940 | $259,257 |
| Federal Funds | $3,942 | $7,634,202 | $7,774,267 |
| Other (Specify) | | | |
| **TOTAL** | **$7,884** | **$11,314,958** | **$11,522,553** |

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 THE ACTION PROPOSED.

1. Provide an estimate of the anticipated impact of the proposed action on local governmental units, including adjustments 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, which will be affected by these costs or savings.

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

**FISCAL AND ECONOMIC IMPACT STATEMENT**
**WORKSHEET**

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

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

| REVENUE INCREASE/DECREASE | FY 22 | FY 23 | FY 24 |
|---|---|---|---|
| State General Fund | | | |
| Agency Self-Generated | | | |
| Dedicated Funds | $0 | $190,940 | $259,257 |
| Federal Funds | $3,942 | $7,634,202 | $7,774,267 |
| Local Funds | | | |
| **TOTAL** | **$3,942** | **$7,825,142** | **$8,033,524** |

*Specify the particular fund being impacted.

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

The amounts reflected above are the estimated increases in statutory dedicated revenue collections and federal revenue collections. In FY 21-22, $3,942 will be collected for the federal share of the administrative expense for promulgation of this proposed rule and the final rule.

**FISCAL AND ECONOMIC IMPACT STATEMENT**
**WORKSHEET**

III. COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS, SMALL BUSINESSES, OR NONGOVERNMENTAL GROUPS

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

This proposed rule, in compliance with Act 450 of the 2021 Regular Session of the Louisiana Legislature amends the provisions governing the New Opportunities Waiver (NOW) in order to add adult dental services as a covered service. In addition, it also proposes to add waiver flexibilities in the delivery of NOW services under certain conditions including allowing family members as paid caregivers, the 16-hour rule and shared services. This proposed rule will benefit NOW beneficiaries by covering adult dental services and allowing flexibility in the delivery of services.

B. Also provide an estimate and a narrative description of any impact on receipts and/or income resulting from this rule or rule change to these groups.

Providers will benefit from implementation of this proposed rule as it is anticipated that it will increase payments for these services by approximately $11,314,958 for FY 22-23 and $11,522,553 for FY 23-24.

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.