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**COVERED SERVICES**

This section provides information about the services that are covered in the Community Choices Waiver (CCW) program. For the purpose of this policy, when reference is made to “individual” or “beneficiary”, this includes that person’s responsible representative, legal representative(s) and/or family member(s), as applicable, who are assisting that person in obtaining services.

**NOTE: Beneficiaries who are approved for CCW cannot receive Long Term - Personal Care Services (LT-PCS).**

**Support Coordination**

Support coordination, also referred to as case management, is a mandatory service in the CCW program. It is designed to assist beneficiaries in prioritizing and defining their personal outcomes and gaining access to necessary waiver and other State Plan services, as well as needed medical, social, educational, housing, and other services, regardless of the funding source for these services. Support coordination agencies must perform the following core elements of support coordination:

1. Intake;
2. Assessment and re-assessment;
3. Plan of care (POC) development and revision;
4. Follow-up/monitoring;
5. Critical incident management; and
6. Transition/discharge and closure.

Support coordination agencies are also required to perform the following duties: s

1. Evaluation/re-evaluation of level of care (LOC) and need for waiver services;
2. Linkage to direct services and other resources;
3. Assessing, addressing, and documenting the delivery of services, including remediation of difficulties encountered by beneficiaries in receiving direct services;
4. Coordination of multiple services among multiple providers;
5. Ongoing assessment and mitigation of health, behavioral and personal safety risks;

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and

6. Responding to beneficiary crises.

The support coordinator is responsible for coordination of the beneficiary's CCW services in a way that does not duplicate services when the beneficiary is also receiving other services, such as home health, or hospice services.

Support coordination services are provided by support coordination agencies. Support coordination agencies shall not refuse to serve, or refuse to continue to serve, any individual who chooses/has chosen the agency unless there is documentation to support an inability to meet the individual's health and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services. The Office of Aging and Adult Services (OAAS) must be immediately notified of the circumstances surrounding a refusal to provide/continue to provide services. This requirement can only be waived by OAAS.

Support coordination agencies must establish and maintain effective communication and good working relationships with each of the beneficiary's service providers.

For additional details on Support Coordination/Support Coordination Agencies responsibilities, procedures, and timelines, refer to Appendix B for the link to OAAS Waiver Procedures Manual: For Regional Offices and Support Coordination Agencies.

Beneficiaries must be given information and assistance in directing and managing their services. When beneficiaries choose to self-direct their personal assistance services (PAS), support coordinators must inform beneficiaries about their responsibilities as a self-direction (SD) employer and compliance with all applicable state and federal laws, rules, policies, and procedures.

Support coordinators shall be available to beneficiaries and/or SD employers for on-going support and assistance in these decision-making areas regarding SD employer responsibilities. (See Appendix B for information on accessing the "*OAAS Community Choices Waiver Self-Direction Employer Handbook*").

### **Transition Intensive Support Coordination**

Transition intensive support coordination (TISC) is a service that assists individuals who are currently residing in nursing facilities who want to transition into the community. This service assists individuals in gaining access to needed waiver and other Medicaid State Plan services, as well as needed medical, social, housing, educational and other services, regardless of the funding source for these services.

TISC services are provided by support coordination agencies. Support coordination agencies shall

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comply with all requirements described in the “Support Coordination” section listed above this section. Support coordination agencies shall initiate and oversee the process for assessment and reassessment, as well as be responsible for ongoing monitoring of the provision of services included in the beneficiary’s approved POC. (See Appendix F for a complete list of the CCW services available during the transition process).

**Service Exclusions**

Support coordination agencies are not allowed to bill for TISC until after the individual has been approved for the CCW.

The scope of TISC shall not overlap with the scope of support coordination; therefore, duplicate billing is not allowed.

**Service Limitations**

Support coordination agencies may be reimbursed up to 6 months (not to exceed 180 calendar days) from the POC approval date for the months that the beneficiary was residing in a nursing facility. Reimbursement is contingent upon the support coordination agency performing activities necessary to arrange for the individual to live in the community. These activities must be documented by the support coordinator. Support coordination agencies will not receive reimbursement for any month during which no activity was performed and documented in the transition process.

**Transition Services**

Transition services assist an individual, who has been approved for a CCW opportunity, to leave a nursing facility and return to live in the community.

Transition services are time limited, non-recurring set-up expenses available for individuals who have been offered and approved for a CCW opportunity, and who are transitioning from a nursing facility to their own living arrangement in a private residence where the individual is directly responsible for their own living expenses. Transition services may also be used to purchase essential items needed for the individual even when the individual is residing with others. Allowable expenses are those necessary to enable the individual to establish a basic household, excluding expenses for room and board. These services must be identified and approved in the individual’s POC in accordance with the Louisiana Department of Health (LDH) and OAAS policies and procedures.

Transition services include the following:

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

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2. Specific set-up fees or deposits for the following:
  - a. Telephone;
  - b. Electricity;
  - c. Gas;
  - d. Water; and
  - e. Other such necessary housing start-up fees or deposits, including outstanding balances for past due charges and/or fees.
3. Activities to assess need, arrange for and procure needed resources (e.g. fees associated with obtaining photo identification cards (IDs) or vital records, housing application fees, etc.);
4. Essential furnishings to establish basic living arrangements, including the following:
  - a. Living room – sofa/love seat, chair, coffee table, end table and recliner;
  - b. Dining room – dining table and chairs;
  - c. Bedroom – bedroom set, mattress/box spring, bed frame, chest of drawers, nightstand, comforter, sheets, pillows, lamp, and telephone;
  - d. Kitchen – refrigerator, stove, cook top, dishwasher, convection oven, dishes/plates, glassware, cutlery/flatware, microwave, coffee maker, toaster, crock pot, indoor grill, pots/pans, drain board, storage containers, blender, can opener, food processor, mixer, dishcloths, towels, and potholders;
  - e. Bathroom – towels, hamper, shower curtain, and bath mat; and
  - f. Miscellaneous – window coverings, window blinds, curtain rod, washer, dryer, vacuum cleaner, air conditioner, fan, broom, mop, bucket, iron, and ironing board.
5. Moving expenses – moving company and cleaners (prior to move, one-time expense); and

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6. Health and welfare assurances, as follows:
  - a. Pest control/eradication;
  - b. Fire extinguisher;
  - c. Smoke detector; and
  - d. First aid supplies/kit.

**NOTE: Support coordinators must exhaust all other resources to obtain these items prior to utilizing the waiver.**

**Service Exclusions**

Transition services do not include the following:

1. Monthly rental payments;
2. Mortgage payments;
3. Food;
4. Monthly utility charges; and
5. Household appliances and/or items intended solely for diversional/recreational purposes (e.g., television, stereo, computer, etc.).

The service exclusions listed above do not constitute room and board. These services may not be used to pay for furnishing or to set-up living arrangements that are owned or leased by a waiver provider.

**Service Limitations**

There is a \$1,500 lifetime maximum limit per beneficiary. Services must be prior approved by the OAAS Regional Office (OAAS RO) or its designee and require prior authorization (PA).

**This waiver service is NOT subject to deduction from the beneficiary's annual POC budget.**

When the beneficiary transitions to a home/apartment that is inhabited with another person, services will only be available for items that are to be used exclusively by the beneficiary.

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The purchaser for these items may be the beneficiary, the responsible representative, the direct service provider, the support coordination agency, or any other source. However, the support coordination agency is the **ONLY** source that can bill for these services.

**Environmental Accessibility Adaptations**

Environmental accessibility adaptations (EAA) are those necessary physical adaptations made to the home to reasonably assure the health and welfare of the beneficiary, or enable the beneficiary to function with greater independence in the home. Without these necessary adaptations, the beneficiary would require institutionalization.

**NOTE: Necessity is determined when all options (Durable Medical Equipment (DME), assistive technology, etc.) have been explored and exhausted, or found to be ineffective for justifiable reasons.**

There must be an identified need for an EAA as indicated by the interRAI Home Care Assessment (iHC) or other supporting documentation.

All costs associated with the EAA service (e.g., initial home evaluation also referred to as the basic assessment, final inspection, costs of DME, costs of construction, etc.) are subject to the beneficiary's annual budget allotment.

If the beneficiary does not own the home, written permission from the landlord **MUST** be obtained prior to proceeding with EAAs which require structural modification(s).

All proposed EAAs documented in the home access evaluation (HAE) report must be reviewed by the OAAS RO before proceeding.

Upon completion of any structural modification(s), the EAA assessor or OAAS must ensure that all specifications have been satisfactorily met before payment shall be made to the provider that completed the work.

**NOTE: If OAAS or the EAA assessor determines that the work of the EAA provider is substandard, the EAA provider who completed the work shall be responsible for the costs associated with bringing the work up to standard, including but not limited to materials, labor, and costs of any subsequent inspections. If the substandard work is the result of the EAA assessor's HAE report, the EAA assessor shall be responsible for the associated costs indicated above.**

The adaptation(s) must be accepted, fully delivered, installed, and operational in the current POC year that it was approved, unless otherwise approved by OAAS or its designee.

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EAs include the following:

1. Ramps, such as:
  - a. Portable; and
  - b. Fixed.
2. Lifts, such as:
  - a. Porch;
  - b. Stair;
  - c. Hydraulic;
  - d. Manual; and
  - e. Electronic.
3. Modifications of bathroom facilities, such as:
  - a. Roll shower;
  - b. Sink;
  - c. Bathtub;
  - d. Toilet; and
  - e. Plumbing.
4. Additions to bathroom facilities, such as:
  - a. Roll shower;
  - b. Water faucet controls;
  - c. Floor urinal;
  - d. Bidet; and

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- e. Turnaround space.
- 5. Specialized accessibility/safety adaptations/additions, such as:
  - a. Door widening;
  - b. Electrical wiring;
  - c. Grab bars;
  - d. Handrails;
  - e. Automatic door opener/doorbell;
  - f. Voice activated, light activated, motion activated, and electronic devices;
  - g. Fire safety adaptations;
  - h. Medically necessary air filtering device\*;
  - i. Medically necessary heating/cooling adaptations\*; and
  - j. Other modifications to the home necessary for medical or personal safety.

**\*A medical doctor's statement concerning medical necessity for air filtering devices and heating/cooling adaptations is required. The support coordinator must obtain such documentation prior to requesting approval from the OAAS RO, or its designee, and must maintain the documentation in the beneficiary's records.**

EAA's shall be authorized only if the beneficiary's health and welfare can be reasonably assured for the duration of the POC year within the beneficiary's remaining resource allocation.

**EAA Service Exclusions**

This service is not intended to cover basic construction costs. For example, in a new home, a bathroom is already part of the building costs and waiver funds can be used to cover the difference between constructing a bathroom and building an accessible or modified bathroom.

The following adaptations are not included in this service:

- 1. General house repairs;



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2. Flooring (carpet, wood, vinyl, tile, stone, marble, etc.);
3. Interior/exterior walls not directly affected by an adaptation;
4. Lighting or light fixtures that are for non-medical use;
5. Furniture;
6. Vehicle adaptations;
7. Roofing, initial or repairs. This also includes covered ramps, walkways, parking areas, etc.;
8. Exterior fences or repairs made to any such structure;
9. Motion detector or alarm systems for security, fire, etc.;
10. Fire sprinklers, extinguishers, hoses, etc.;
11. Smoke, fire, and carbon monoxide detectors;
12. Interior/exterior non-portable oxygen sites;
13. Replacement of toilets, septic system, cabinets, sinks, counter tops, faucets, windows, electrical or telephone wiring or fixtures when not affected by an adaptation, not part of the installation process or not one of the pieces of medical equipment being installed;
14. Appliances (washer, dryer, stove, dishwasher, vacuum cleaner, etc.);
15. Any service covered by the Medicaid State Plan; or
16. Any equipment or supply covered by Medicaid DME program.

**NOTE: Some lifts, filters, etc., may be covered as a DME item. The support coordinator must first explore the possibility of these items being covered through the DME program by assisting the beneficiary in making a PA request with a DME provider.**

**Service Limitations**

Services must be reviewed by the OAAS RO or its designee and be prior authorized.

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It is strictly prohibited for the EAA provider to charge the beneficiary an amount in excess of the prior approved amount for completion of the job.

**Personal Assistance Services**

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

1. Supervision or assistance in performing activities of daily living (ADLs);
2. Supervision or assistance in performing instrumental activities of daily living (IADLs);
3. Protective supervision solely to assure the health and welfare of the beneficiary;
4. Supervision or assistance with health-related tasks (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 beneficiary outside the home to perform tasks, including IADLs, health maintenance or other needs as identified in the POC and to provide the same supervision or assistance as would be provided in the home; and
6. Extension of therapy services, defined as the following:
  - a. Assistance in reinforcing instruction and aids in the rehabilitative process by an attendant who has been instructed by a licensed therapist on the proper way to assist the beneficiary in follow-up therapy sessions; and
  - b. Performance of basic interventions by an attendant who has been instructed by a registered nurse (RN) on how to increase and optimize functional abilities in performing ADLs, such as range of motion exercise.

Transportation is not a required component of PAS although providers may choose to furnish transportation for beneficiaries during the course of providing PAS. If transportation is furnished, the provider must accept all liability for its employee transporting a beneficiary. It is the responsibility of the provider to ensure that the employee has a current, valid driver's license and automobile liability insurance.

PAS workers can be any one of the following relations of the beneficiary, as long as they meet the

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worker requirements:

1. Spouse\*;
2. Curator;
3. Tutor;
4. Legal guardian; or
5. Person to whom the beneficiary has given representative and mandate authority (also known as power of attorney).

\*For the spouse to be the worker, refer to Legally Responsible Individual (LRI)/Spouse and Extraordinary Care Criteria section later in this section.

PAS is provided in the beneficiary's home or can be provided in another location outside of the beneficiary's home if the provision of these services allows the beneficiary to participate in normal life activities pertaining to the ADLs and IADLs cited in the POC. In cases where a beneficiary goes to the Emergency Room, the PAS direct service worker (DSW) may provide assistance up until the time the beneficiary is admitted to the hospital.

When beneficiaries plan to travel outside of Louisiana, there must be a written request (that includes a detailed explanation) submitted to OAAS or its designee at least 24 hours prior to the anticipated travel (when applicable).

The PAS allotment may be used flexibly in accordance with the beneficiary's preferences and personal schedule and with OAAS' documentation requirements when the following guidelines are met:

1. Approved allocation must be used in accordance with the beneficiary's preferences within a single, specific PA period;
2. Unused portions of the prior authorized allocation may not be saved or borrowed from one prior authorized period to another;
3. Total hours used may not exceed the prior authorized period amount;
4. Variations from the approved POC in accordance with the beneficiary's preference must be documented by the DSW on the designated CCW service log (See Section 7.7 – *Record Keeping* of this manual chapter); and

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5. **Need** for paid support/assistance with particular tasks/services, without assignment of specific time per task, must be documented in the approved POC.

**Supervision or Assistance with ADLs**

Beneficiaries may receive supervision or assistance in performing the following ADLs for their continued well-being and health:

1. Eating, including the following:
  - a. Verbally reminding the beneficiary to eat;
  - b. Cutting food into bite-size pieces;
  - c. Assisting the beneficiary with feeding; and/or
  - d. Assisting the beneficiary with adaptive feeding devices.

**NOTE: Assistance does NOT include tube feeding unless the DSW has received the required training pursuant to La. R.S. 37:1031-1034.**

2. Bathing, including the following:
  - a. Verbally reminding the beneficiary to bathe;
  - b. Preparing the beneficiary's bath;
  - c. Assisting the beneficiary with dressing and undressing; or
  - d. Assisting the beneficiary with prosthetic devices.
3. Dressing, including the following:
  - a. Verbally reminding the beneficiary to dress;
  - b. Assisting the beneficiary with dressing and undressing; or
  - c. Assisting the beneficiary with prosthetic devices.

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4. Grooming, including the following:
  - a. Verbally reminding the beneficiary to groom;
  - b. Assisting the beneficiary with shaving, applying make-up, body lotion or cream;
  - c. Brushing or combing the beneficiary's hair;
  - d. Brushing the beneficiary's teeth; or
  - e. Other grooming activities.
5. Transferring, including the following:
  - a. Assisting the beneficiary with moving body weight from one surface to another, such as moving from a bed to a chair; or
  - b. Assisting the beneficiary with moving from a wheelchair to a standing position.
6. Ambulation, including the following:
  - a. Assisting the beneficiary with walking (regardless of assistive device); or
  - b. Assisting the beneficiary with wheelchair use.
7. Toileting, including the following:
  - a. Verbally reminding the beneficiary to toilet;
  - b. Assisting the beneficiary with bladder and/or bowel requirements, including bedpan routines and changing incontinence pads or adult briefs, if required; or
  - c. Draining/emptying a catheter or ostomy bag.

**NOTE: Assistance does NOT include removing or changing catheter and/or ostomy bags or tubing, inserting, removing, and sterilizing irrigation of catheters unless the DSW has received the required training pursuant to La. R.S. 37:1031-1034.**

Assistance or support with ADL tasks does not include teaching family/friends/others how to care for the beneficiary.

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**Supervision or Assistance with IADLs**

Beneficiaries may receive supervision or assistance in performing routine household tasks that may not require performance on a daily basis, but are essential for sustaining their health and welfare. **The purpose of providing assistance or support with these tasks is to meet the needs of the beneficiary, not the housekeeping needs of the beneficiary's household.** Assistance or support with IADLs includes the following:

1. Light housekeeping, including the following:
  - a. Vacuuming and mopping floors;
  - b. Cleaning the bathroom and kitchen;
  - c. Making the beneficiary's bed; or
  - d. Ensuring pathways are free from obstructions.
2. Food preparation and food storage as required specifically for the beneficiary;
3. Shopping (with or without the beneficiary) for items specifically for the beneficiary including the following:
  - a. Groceries;
  - b. Personal hygiene items;
  - c. Medications; or
  - d. Other personal items.
4. Laundry of the beneficiary's clothing and bedding;
5. Medication reminders with self-administered prescription and non-prescription medication that is limited to the following:
  - a. Verbal reminders;
  - b. Assistance with opening the bottle or bubble pack;
  - c. Reading the directions from the label;

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- d. Checking the dosage according to the label directions; or
- e. Assistance with ordering medication from the drug store.

**NOTE: Assistance does NOT include taking medication from the bottle to set up pill organizers, administering medications, and applying dressing that involves prescription medication and aseptic techniques of skin problems, unless the DSW has received the required training pursuant to La. R.S. 37:1031-1034.**

- 6. Assistance with scheduling (making contacts and coordinating) medical appointments including, but not limited to appointments with the following:
  - a. Physicians;
  - b. Physical therapists;
  - c. Occupational therapists; and
  - d. Speech therapists.
- 7. Assistance in arranging medical transportation depending on the needs and preferences of the beneficiary with the following:
  - a. Medicaid emergency medical transportation;
  - b. Medicaid non-emergency medical transportation;
  - c. Public transportation; and
  - d. Private transportation.
- 8. Accompanying the beneficiary to medical appointments and provide assistance throughout the appointment.

**Protective Supervision**

Protective supervision may be provided to assure the health and welfare of a beneficiary who has cognitive or memory impairment or who has physical weakness as defined by the OAAS comprehensive assessment. The worker must be with the beneficiary and:

- 1. Be awake;

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2. Be alert; and
3. Available to respond to the beneficiary's immediate needs.

**Supervision or Assistance with Health-Related Tasks**

Supervision or assistance with health-related tasks, as specified in the POC, may be provided to beneficiaries (any health related procedures governed under the Nurse Practice Act where the DSW has received the required training pursuant to La. R.S. 37:1031-1034). Supervision or assistance includes, but is not limited to, medication administration.

**Supervision or Assistance while Escorting/Accompanying with Community Tasks**

Supervision or assistance may be provided to beneficiaries while escorting or accompanying the beneficiary outside of the home to perform tasks, including IADLs, health maintenance or other needs as identified in the POC, and to provide the same supervision or assistance as would be rendered in the home.

**Extension of Therapy Services**

Licensed therapists may choose to instruct attendants on the proper way to assist the beneficiary in follow-up therapy sessions to reinforce and aid the beneficiary in the rehabilitative process. The attendant may also be instructed by a RN to perform basic interventions with the beneficiary that would increase and optimize functional abilities for maximum independence in performing ADLs such as range of motion exercise. Instruction provided by licensed therapists and RNs must be documented.

**Shared Personal Assistance Services**

PAS may be provided by 1 worker for up to 3 CCW beneficiaries who live together and have a common direct service provider (DSP). Beneficiaries receiving shared PAS must each be:

1. Approved to receive CCW;
2. Share the same residence; and
3. Have a common DSP.

Waiver beneficiaries may share PAS staff when agreed to by the beneficiaries, and the health and welfare of each beneficiary can be reasonably assured. Shared PAS is to be identified in the



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approved POC of each beneficiary. Reimbursement rates are adjusted accordingly. Due to the requirements of privacy and confidentiality, beneficiaries who choose to share these services must agree to sign the “Release of Confidentiality for Shared PAS or LT-PCS” form to facilitate the coordination of services. (See Appendix B for a link to this form).

**A.M. / P.M. Delivery Method**

PAS may be provided through an “a.m. / p.m.” delivery method. This delivery method provides PAS to the beneficiary at the beginning and/or end of the day.

PAS providers must be able to provide both regular and “a.m.” and “p.m.” PAS and cannot refuse to accept a CCW beneficiary solely due to the type of PAS delivery method that is listed on the POC.

**Legally Responsible Individual/Spouse and Extraordinary Care Criteria**

For purposes of the CCW program, a Legally Responsible Individual (LRI) is defined as a spouse who has a legal obligation, under state law, to care for another person. An LRI’s legal (unpaid) obligation to care for the beneficiary includes routine care such as cooking/cleaning, regular family interactions and any legally indicated activities (medical/financial decisions).

Extraordinary care is defined as:

1. Activities which require an LRI/beneficiary’s spouse to exceed the range of activities that would ordinarily be performed for an individual the same age without a disability/chronic illness; **AND**
2. Necessary to assure the health and welfare of the beneficiary and to avoid institutionalization.

The LRI/beneficiary’s spouse, can **ONLY** be the PAS DSW for the CCW beneficiary, if **ALL** of the following conditions are met:

1. The current iHC assessment and/or beneficiary’s POC indicates that the beneficiary has extraordinary health care needs **AND** extraordinary care is necessary;
  - a. Extraordinary Health Care Needs Criteria - Beneficiary’s behavioral, dementia related or nursing care needs as identified in the iHC assessment and/or the POC, such as but not limited to the following:
    - i. Oxygen;

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- ii. Tube feeding;
- iii. Suctioning (this includes oropharyngeal, nasopharyngeal, and/or tracheal aspiration);
- iv. Physical therapy (PT)/occupational therapy (OT);
- v. Incontinence (with the use of urinary collection device\* or ostomy);
- vi. Stage 4 or non-codeable pressure ulcers;
- vii. Dialysis; and/or
- viii. Hospice.

\*A urinary collection device is a catheter or other product that drains urine via tubing attached to a bag or container. Bed pans and hand held collection devices are not included.

- b. Extraordinary Care Criteria - Beneficiary's lack of qualified support staff confirmed by:
  - i. The inability to locate or hire staff;
  - ii. Staff that apply are not able to provide the needed supports; and/or
  - iii. The spouse has a unique ability to meet the needs of the beneficiary (i.e. special skills, training, license that is tied to the support needed).

- 2. It is in the best interest of the beneficiary.

If OAAS determines that the LRI/spouse meets the "extraordinary" care criteria and the beneficiary meets the criteria for "extraordinary" health care needs, the LRI/spouse can serve as beneficiary's PAS DSW.

If the beneficiary believes that it is necessary for their spouse to be their worker, the beneficiary **MUST** inform their PAS DSP or SD employer.

The DSP or SD employer will complete the LRI/Spouse Request Form and email it to the OAAS RO for further review/processing. If additional information is needed, OAAS RO will request it from the DSP or SD employer. Once a final decision is made, OAAS RO will notify the DSP or

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SD employer and Fiscal/Employer Agent (F/EA) and the support coordinator.

If approved:

1. The support coordinator will document in the beneficiary's POC documentation;
2. The DSP will proceed with hiring the spouse as the worker per their usual hiring processes outlined in their licensing regulations; and
3. The SD employer/F/EA will proceed with hiring the spouse as the DSW per their usual hiring processes outlined in the OAAS CCW Self-Direction Employer Handbook and licensing regulations.

If NOT approved:

1. The support coordinator will contact the DSP or SD employer to ensure that they understand that the spouse **CANNOT** be the worker; and
2. The DSP or SD employer will need to find another worker that can meet the beneficiary's needs.

**Service Exclusions**

PAS providers may not bill for this service until after the individual has been approved for CCW.

PAS may not be billed at the same time of service as adult day health care (ADHC) and caregiver temporary support services.

The beneficiary's responsible representative is prohibited from being the PAS worker.

Beneficiaries are not permitted to receive PAS while living in a home or property owned, operated, or controlled by an owner, operator, agent, or employee of their PAS provider. Furthermore, providers are prohibited from providing and billing for services under these circumstances. Beneficiaries may not live in the home of a DSW unless the DSW is related to the beneficiary and it is the choice of the beneficiary. These provisions may be waived with prior written approval by OAAS or its designee on a case-by-case basis.

**NOTE: For more details and specifics on who can and cannot be the PAS DSW and who the beneficiary can and cannot live with, see Appendix B for the link to the "CCS PAS: DSW/Participant Relationship and Living Arrangements Guidance" document.**

**Service Limitations**

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There shall be no duplication of services.

PAS may not be provided while the beneficiary is admitted to a program or service that provides in-home assistance with ADLs and/or IADLs or while admitted to a program or setting where such assistance is provided (e.g. hospitals, nursing facilities, etc.). Therefore, PAS DSWs CANNOT receive payments on days that the beneficiary is admitted to a program or setting that provides ADLs and/or IADL assistance. IADLs may not be performed in the beneficiary's home when the beneficiary is absent from the home, unless it is approved by OAAS or its designee on a case-by-case basis.

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

PAS cannot be provided or billed at the same hours on the same day as shared PAS.

Beneficiaries cannot receive PAS from the "a.m./p.m." delivery method **on the same calendar day** as other PAS service delivery methods.

Beneficiaries utilizing the "a.m. / p.m." delivery method must be provided with at least 1 hour, but no more than 2 hours, of service during each session. If both the "a.m." and the "p.m." sessions are provided, there must be at least a 4-hour break between the 2 sessions.

Shared PAS cannot be billed on behalf of a beneficiary who was not present to receive the service.

"A.m. /p.m." PAS cannot be shared.

A home health agency is limited to providing services within a 50-mile radius of its parent agency. This limit may be waived by the appropriate LDH authority on a case-by-case basis as needed.

### **Adult Day Health Care Services**

ADHC services provide a planned, diverse daily program of individual services and group activities structured to enhance the beneficiary's physical functioning and to provide mental stimulation. ADHC services are furnished as specified in the POC at an ADHC center, in a licensed non-institutional, community-based setting encompassing both health/medical and social services needed to ensure the optimal functioning of the beneficiary.

An ADHC center shall, at a minimum, furnish the following services in accordance with licensing regulations:

1. Training or assistance with ADLs (toileting, grooming, eating, ambulation, etc.);

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2. Health and nutrition counseling;
3. Individualized daily exercise program;
4. Individualized, goal-directed recreation program;
5. Health education;
6. Medical care management;
7. One nutritionally-balanced hot meal and a minimum of two snacks served each day;

**NOTE: The ADHC center may serve breakfast in place of a mid-morning snack. Also, providers must allow flexibility with their food and dining options to reasonably accommodate a beneficiary's expressed needs and preferences.**

8. Nursing services that are provided by licensed nursing professionals and that include the following individualized health services:
  - a. Monitoring vital signs appropriate to the diagnosis and medication regimen of each beneficiary no less frequently than monthly;
  - b. Administering medications and treatments in accordance with physicians' orders;
  - c. Developing and monitoring beneficiary's medication administration plans (self-administration and staff administered) of medications while the beneficiary is at the ADHC center; and
  - d. Serving as a liaison between the beneficiary and the medical resources including the treating physician.

**NOTE: All nursing services shall be provided in accordance with professional practice standards and all other requirements identified in the ADHC licensing rules – LAC Title 48: Part I. Subpart 3. Chapter 42. ADHC – “Nursing Services”.**

9. Transportation between the beneficiary's place of residence and the ADHC center at the beginning and end of the program day, which includes the following:

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- a. The cost of transportation is included in the rate paid to ADHC centers. The beneficiary and their family may choose to transport the beneficiary to the ADHC center. Transportation provided by the beneficiary's family is not a reimbursable service; and

**NOTE: An ADHC center may serve a person residing outside of the ADHCs licensed region. However, transportation by the ADHC center is NOT required.**

- b. Transportation to and from medical and social activities when the beneficiary is accompanied by ADHC center staff.

ADHC providers must adhere to the ADHC center requirements as outlined in the ADHC Licensing Rule – LAC Title 48: Part I. Subpart 3. Chapter 42. ADHC – Subchapter D. ADHC Center Services.

**Service Exclusions**

ADHC providers shall not bill for this service until after the individual has been approved for the CCW.

ADHC services may not be billed at the same time as PAS, monitored in-home caregiver (MIHC), home delivered meals (HDMs), and/or caregiver temporary support services.

ADHC center attendance days shall not overlap with HDMs or MTMs.

**Service Limitations**

These services must be provided in the ADHC center that has been chosen by the beneficiary.

ADHC services are furnished on a regularly scheduled basis, not to exceed 10 hours per day, 50 hours per week (exclusive of transportation time to and from the ADHC center, as specified in the beneficiary's POC and ADHC individualized service plan (ISP)).

**Caregiver Temporary Support Service**

Caregiver temporary support service is furnished on a short-term basis because of the absence or need for relief of caregivers during the time they would normally provide unpaid care for the beneficiary. The purpose of caregiver temporary support is to provide relief to unpaid caregivers or principal caregivers of beneficiaries who receive MIHC services to maintain the beneficiary's informal support system. Federal financial participation is not claimed for the cost of room and

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board except when provided as part of caregiver temporary support service furnished in a facility approved by the state that is not a private residence.

Caregiver temporary support service is provided in the following locations:

1. Beneficiary's home or place of residence;
2. Nursing facilities;
3. Assisted living facilities/adult residential care facilities;
4. Respite centers; or
5. ADHC centers.

Caregiver temporary support services may be provided in the beneficiary's home by a Medicaid enrolled personal care attendant (PCA) or home health agency.

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

Caregiver temporary support services that are provided by an ADHC center may not be provided for more than 10 hours per day.

**Service Exclusions**

Caregiver temporary support service may not be delivered/billed at the same time as PAS or ADHC services.

**Service Limitations**

These services must be prior approved by the OAAS RO or its designee.

Caregiver temporary support service may be utilized for no more than 30 calendar days or 29 overnight stays per POC year, for no more than 14 consecutive days or 13 consecutive overnight stays.

These service limits may be increased based on documented need.

**Monitored In-Home Caregiving Services**

MIHC services are services provided to a beneficiary living in a private home with a principal caregiver. This service provides a community-based option of continuous care, supports, and

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professional oversight by promoting a cooperative relationship between the beneficiary, principal caregiver, professional staff of a MIHC provider, and the beneficiary's support coordinator. When beneficiaries plan to travel outside of Louisiana, there must be a written request (that includes a detailed explanation) submitted to OAAS or its designee at least 24 hours prior to the anticipated travel (when applicable).

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 the following:

1. Supervision or assistance in performing ADLs;
2. Supervision or assistance in performing IADLs;
3. Protective supervision provided solely to assure the health and welfare of a beneficiary;
4. Supervision or assistance with health related tasks (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 beneficiary outside of the home to perform tasks, including IADLs, health maintenance or other needs as identified in the POC and to provide the same supervision or assistance as would be rendered in the home; and
6. Extension of therapy services to maximize independence when the caregiver has been instructed in the performance of the activities by a licensed therapist or RN.

Providers capture daily notes electronically to monitor the beneficiary's health and the principal caregiver's performance. The daily notes must be available to support coordinators and LDH upon request.

Principal caregivers can be any of the following relations to the beneficiary:

1. Spouse;
2. Curator;
3. Tutor;
4. Legal guardian; or



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5. Person to whom the beneficiary has given representative and mandate authority (also known as power of attorney).

**Service Exclusions**

Unless the individual is also the beneficiary's spouse, the beneficiary's responsible representative is prohibited from being the MIHC principal caregiver.

**Service Limitations**

Beneficiaries electing MIHC services are not eligible to receive the following CCW services during the period of time that the beneficiary is receiving MIHC services:

1. PAS; or
2. HDM services.

Beneficiaries can receive MIHC and ADHC services; however, MIHC and ADHC services **CANNOT** be received on the same day, in order to avoid duplication of services.

MIHC providers shall not bill and/or receive payment on days that the beneficiary is attending or admitted to a program or setting (e.g., hospitals, nursing facilities, etc.) which provides ADL or IADL assistance.

The provision of MIHC services outside of the borders of the state (e.g., temporary excursions, vacations, etc.) is prohibited without prior written approval by OAAS or its designee.

**Assistive Devices and Medical Supplies**

Assistive devices and medical supplies (ADMS) are specialized medical equipment and supplies that include the following:

1. Devices, controls, appliances, or nutritional supplements specified in the POC that enable beneficiaries to increase their abilities to perform ADLs;
2. Devices, controls, appliances, or nutritional supplements specified in the POC to perceive, control, or communicate with the environment in which the beneficiary lives or to provide emergency response;
3. Items, supplies, and services necessary for life support, ancillary supplies, and

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equipment necessary to the proper functioning of such items;

4. Supplies and services to assure beneficiaries' health and welfare, including pest control/eradication;
5. Other durable and non-durable medical equipment and necessary medical supplies that are not available under the Medicaid State Plan;
6. Personal Emergency Response System (PERS);
7. Other in-home monitoring and medication management devices and technology;
8. Routine maintenance or repair of specialized equipment; and
9. Batteries, extended warranties, and service contracts that are cost effective and assure health and welfare.

This includes medical equipment not available under the Medicaid State Plan that is necessary to address beneficiary functional limitations, and necessary medical supplies not available under the Medicaid State Plan that are included in the POC or other supporting documentation (e.g. assessment, support coordination documentation, etc.).

All costs associated with this service are subject to the beneficiary's annual budget allotment.

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

**Personal Emergency Response System**

PERS is an electronic device that enables the beneficiary to secure help in an emergency.

The unit is connected to the telephone line or a wireless communication device and is programmed to send an electronic message to a community-based 24-hour emergency response center when a "help" button is activated. This unit may either be worn by the beneficiary or installed in their home. It must meet Federal Communications Commission (FCC) standards or Underwriter's Laboratory (UL) standards or equivalent standards.

PERS services are appropriate for beneficiaries who are cognitively and/or physically able to operate the system. PERS is a measure to promote the health and welfare of the beneficiary.

The PERS unit shall be rented from the PERS provider.

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The PERS must be checked monthly by the provider to ensure it is functioning properly. The PERS battery/unit must be checked once every quarter by the support coordinator during the home visit/quarterly virtual contact.

**Telecare**

Telecare is a delivery of care services to beneficiaries in their home by means of telecommunications and/or computerized devices to improve outcomes and quality of life, increase independence and access to health care, and reduce health care costs. Telecare services include the following:

1. Activity and sensor monitoring;
2. Health status monitoring; and
3. Medication dispensing and monitoring.

Monthly telecare services consist of the following:

1. Delivering, furnishing, maintaining, and repairing/replacing equipment on an ongoing basis. This may be done remotely as long as all routine requests are resolved within three business days;
2. Monitoring of beneficiary-specific service activities by qualified staff;
3. Training the beneficiary and/or the beneficiary's responsible representative in the use of the equipment;
4. Cleaning and storing equipment;
5. Providing remote teaching and coaching as necessary to the beneficiary and/or caregiver(s); and
6. Analyzing data, developing and documenting interventions by qualified staff based on information/data reported.

All telecare providers must make documentation collected from telecare services available to the support coordinator and OAAS upon request.

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**Activity and Sensor Monitoring**

Activity and sensor monitoring (ASM) is a computerized system that monitors the beneficiary's in-home movement and activity for health, welfare, and safety purposes. The system is individually calibrated based on the beneficiary's typical in-home movements and activities. The provider is responsible for monitoring electronically generated information, for responding as needed, and for equipment maintenance. At a minimum, the system shall include the following:

1. Monitor the home's points of egress;
2. Detect falls;
3. Detect movement or the lack of movement;
4. Detect whether doors are opened or closed; and
5. Provide a push-button emergency alert system.

The ASM system:

1. Is monitored by a call center;
2. Monitors the beneficiary's activity in the home; and
3. Learns the beneficiary's routines.

When the ASM system detects something out of the ordinary, the system generates messages to the beneficiary's list of identified caregivers. This system works through non-invasive sensors and motion detectors placed strategically around the home (e.g. in the bed, in the beneficiary's recliner in the living room, the kitchen door, exterior doors, the bathroom door, cabinet door containing medication, etc.) to ensure that the beneficiary's needs are being met, as well as the beneficiary's health and welfare. The placement of the sensors and/or monitors are based on the specific needs of the beneficiary as identified in the beneficiary's assessment and/or POC.

This service:

1. Only monitors the beneficiary's activity;
2. Decreases a beneficiary's one-on-one care; and
3. Assists the beneficiary in maintaining their independence so they may participate in community activities more easily.

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**NOTE: Some systems may also monitor the home's temperature.**

**Health Status Monitoring**

The health status monitoring (HSM) service collects health-related data to assist the health care provider in assessing the beneficiary's health condition and in providing the beneficiary with education and consultation. The data is collected electronically from the beneficiary using wireless technology or a phone line and assists the healthcare provider in assessing the beneficiary's health. HSM may be helpful to beneficiaries with chronic medical conditions such as congestive heart failure, diabetes, or pulmonary disease in monitoring the beneficiary's:

1. Weight;
2. Oxygen saturation measurements (pulse oximetry); and
3. Vital signs (pulse, blood pressure, etc.).

Peripheral equipment used must be capable of interfacing with the telecare health status monitoring equipment.

**Medication Dispensing and Monitoring**

The medication dispensing and monitoring service assists the beneficiary by dispensing medication and monitoring medication compliance. A remote monitoring system is individually pre-programmed to dispense and monitor the beneficiary's compliance with medication therapy. The provider or family caregiver is notified when there are missed doses or non-compliance with medication therapy.

Dispensing and monitoring devices must have the ability to send text or e-mail messages to the beneficiary's caregiver should the medication not be taken or there is a problem with the equipment.

Dispensing and monitoring systems may include a web-based component for dosage programming, monitoring, and/or communication.

**Service Exclusions**

No experimental items are allowed.

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**Service Limitations**

The purchaser for assistive device/equipment purchases and/or medical supply purchases may be the beneficiary, the responsible representative, the direct service provider, the support coordination agency, or any other source. However, only the support coordination agency or the assistive devices provider can bill and be reimbursed for these services.

**NOTE: The biller of this purchase(s) is not responsible for the interest accrued from the date of purchase(s) to the date of payment release.**

Services must be based on a verified need of the beneficiary and the service must have a direct or remedial benefit with specific goals and outcomes.

The benefit must be determined by an independent assessment on any item that costs over \$500 and on all communication devices, mobility devices, and environmental controls.

Independent assessments must be performed by individuals who have no fiduciary relationship with the manufacturer, supplier, or vendor of the item.

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

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

The items must be on the POC developed by the support coordinator and are subject to approval by OAAS RO or its designee.

A beneficiary will not be able to simultaneously receive telecare activity and sensor monitoring services and traditional PERS services.

**Home Delivered Meals**

HDMs assist beneficiaries in meeting their nutritional needs to support and maintain self-sufficiency and enhance their quality of life.

HDMs include up to 2 nutritionally balanced meals per day to be delivered to the home of a beneficiary who is:

1. Unable to leave the home without assistance;
2. Unable to prepare their own meals; and/or
3. Has no responsible caregiver in the home.

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The HDM service is to provide the beneficiary a minimum of 1/3 of the current recommended dietary allowance (RDA) as adopted by the United States Department of Agriculture (USDA). The provision of HDMs does not provide a full nutritional regimen.

Meals are delivered to the beneficiary's home.

**Service Exclusions**

HDMs shall not overlap with ADHC services/center attendance days.

**Service Limitations**

HDMs are limited to 2 per day. It is permissible for beneficiaries to have some meals delivered daily and others delivered in bulk by different providers as long as the maximum of 2 meals per day is not exceeded. There is a maximum cost per meal. (See Appendix C for the link to the fee schedule).

HDM providers **CANNOT** bill HDMs on the days that the beneficiary attends the ADHC center.

**Medically Tailored Meals**

Medically tailored meals (MTMs) assists beneficiaries with certain chronic conditions in meeting their nutritional needs to support and maintain self-sufficiency and enhance their quality of life when they are discharging from the hospital and/or nursing facility.

MTMs includes up to 2 nutritionally balanced meals per day to be delivered to the home of a beneficiary who:

1. Has the following chronic conditions:
  - a. Congestive heart failure;
  - b. Diabetes;
  - c. Renal disease;
  - d. Oral dysphagia;
  - e. Gluten intolerance;

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- f. Stroke;
  - g. Chronic Obstructive Pulmonary Disease (COPD);
  - h. Cancer; and/or
  - i. Hypertension.
2. Is discharging from a hospital (from an inpatient admission) and/or nursing facility.

Beneficiaries may also receive nutritional counseling to support healthy food choices for their 3<sup>rd</sup> meal and snacks.

MTMs provide the beneficiary a minimum of 1/3 of the current RDA as adopted by the USDA. The provision of MTMs does not provide a full nutritional regimen.

All MTMs are developed under the supervision of a registered dietician (RD)/registered dietician nutritionist (RDN)/licensed dietitian nutritionist (LDN) and must comply with the current Dietary Guidelines for Americans as published by the United States Department of Health and Human Services (HHS) and the USDA, meet the current RDA/dietary reference intakes (DRI) established by the Food and Nutrition Board of Institute of Medicine of the National Academy of Sciences and follow current standards for specific diseases or conditions.

RD/RDN/LDN must be credentialed and in good standing with the Commission on Dietetics Registration.

**Nutritional Counseling**

Nutritional counseling provides supports to beneficiaries with certain chronic medical conditions (as identified above) via:

- 1. In-person;
- 2. By telephone; or
- 3. Telehealth.

This service provides guidance to beneficiaries, including but not limited to the following:

- 1. Healthy eating choices;
- 2. Healthy food options;



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3. Reading food labels; and
4. Meal planning.

Beneficiaries may also receive nutritional counseling to support healthy food choices for their 3<sup>rd</sup> meal (as MTMs are limited to 2 meals per day) and snacks.

Nutritional counseling must be provided by a:

1. Registered dietitian (RD);
2. Registered dietitian nutritionist (RDN); or
3. Licensed dietitian nutritionist.

The nutritional counselor will complete an evaluation specific to the beneficiaries' medical diagnoses and a medically appropriate nutrition care plan that follow current standards for specific diseases or conditions.

Nutritional counselor(s) must be:

1. Licensed to practice in the state by the Louisiana Board of Examiners in Dietetics and Nutrition; and
2. Credentialed and in good standing with the Commission on Dietetics Registration.

**Service Exclusions**

MTMs shall not overlap with HDMs and/or ADHC center attendance days. Duplicate billing is not allowed.

**Service Limitations**

MTMs limitations include:

1. Two meals per day for up to 12 weeks beginning the 1<sup>st</sup> day of meal delivery after the beneficiary is discharged from a hospital or a nursing facility; and
2. No more than two 12 weeks of MTMs per POC year.

There is a maximum cost of MTMs per meal. (See Appendix C for the link to the fee schedule).

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CCW beneficiaries receiving MIHC services cannot receive HDMs and MTMs/nutritional counseling.

Nutritional counseling services are limited to three sessions per 12 weeks of MTM home delivery post discharge from hospital or nursing facility. The maximum cost is \$49.00 per nutritional counseling session.

**MTMs/NC is funded through ARPA funds and is NOT deducted from the beneficiary's annual POC budget.**

**Nursing**

Nursing services are services that are medically necessary and may be provided efficiently and effectively by a nurse practitioner (NP), RN, or a licensed practical nurse (LPN) working under the supervision of an RN. Nursing services must be provided within the scope of the Louisiana Statutes governing the practice of nursing.

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

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

Nursing services may also be used to assess a beneficiary's need for assistive devices or home modifications/EAA's training the beneficiary and family members in the use of the purchased devices, and training of DSWs in tasks necessary to carry out the POC.

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

**Service Exclusions**

Nursing care shall not be provided when the beneficiary is an inpatient at a hospital or in a nursing facility. Assessments are allowed. (See Appendix F for a list of concurrent services).

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**Service Limitations**

Services must be approved by the OAAS RO or its designee and be prior authorized.

Services must be based on a verified need of the beneficiary.

Services must have a direct or remedial benefit to the beneficiary with specific goals and outcomes.

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

**NOTE: Providers are not required to have a doctor's order for an assessment and treatment/service before this service is reimbursed by CCW. Providers may be required to have a doctor's order for assessments and treatment/services before this service is reimbursed by other payers.**

**Skilled Maintenance Therapy (Physical, Occupational, and Speech/Language)**

Skilled maintenance therapy (SMT) includes PT, OT, and/or speech and language therapy that may be received by CCW beneficiaries in their home, work, or in a rehabilitative center/clinic.

SMT services provided to beneficiaries under the waiver are not necessarily tied to an episode of illness or injury and instead focus primarily on the beneficiary's functional need for maintenance of, or reducing the decline in, the beneficiary's ability to carry out ADLs.

SMTs may also be used to assess a beneficiary's need for assistive devices or home modifications/EAAs, training the beneficiary and family members in the use of the purchased devices, performance of in-home fall prevention assessments, and participation on the POC planning team. Services may be provided in the beneficiary's home or in a variety of locations as approved by the POC planning team.

**Physical Therapy**

PT services promote the maintenance of, or reduction in the loss of, gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities. Specific services may include:

1. Professional assessments;
2. Evaluations and monitoring for therapeutic purposes;

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3. PT treatments and interventions;
4. Training regarding PT activities;
5. Use of equipment and technologies;
6. Designing, modifying or monitoring the use of related environmental modifications;
7. Designing, modifying, and monitoring the use of related activities supportive to the POC goals and objectives; or
8. Consulting or collaborating with other service providers or family members, as specified in the POC.

**Occupational Therapy**

OT services promote the maintenance of, or reduction in, the loss of fine motor skills, coordination, sensory integration, and/or facilitate the use of adaptive equipment or other assistive technology.

Specific services may include the following:

1. Teaching of daily living skills;
2. Development of perceptual motor skills and sensory integrative functioning;
3. Design, fabrication, or modification of assistive technology or adaptive devices;
4. Provision of assistive technology services;
5. Design, fabrication, or applying selected orthotic or prosthetic devices or selecting adaptive equipment;
6. Use of specifically designed crafts and exercises to enhance function;
7. Training regarding OT activities; and
8. Consulting or collaborating with other service providers or family members as specified in the POC.

**Speech Language Therapy**

Speech language therapy services preserve abilities for independent function in communication,

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facilitate oral motor and swallowing function, facilitate use of assistive technology, and/or prevent progressive disabilities.

Specific services may include the following:

1. Identification of communicative or oropharyngeal disorders;
2. Prevention of communicative or oropharyngeal disorders;
3. Development of eating or swallowing plans and monitoring their effectiveness;
4. Use of specifically designed equipment, tools, and exercises to enhance function;
5. Design, fabrication, or modification of assistive technology or adaptive devices;
6. Provision of assistive technology services;
7. Adaptation of the beneficiary's environment to meet their needs;
8. Training regarding speech language therapy activities; and
9. Consulting or collaborating with other service providers or family members as specified in the POC.

**Service Exclusions**

Providers may not bill for services until after the individual has been approved for the CCW program and PA has been issued.

SMTs shall not be provided when the beneficiary is an inpatient at a hospital.

**Service Limitations**

Services must be based on a verified need of the beneficiary.

The service must have a direct or remedial benefit to the beneficiary with specific goals and outcomes.

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

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**Housing Transition or Crisis Intervention Services and Housing Stabilization Services**

These housing support services assist waiver beneficiaries to obtain and maintain successful tenancy in Louisiana's Permanent Supportive Housing (PSH) program.

**Housing Transition or Crisis Intervention Services**

Housing transition or crisis intervention services enable beneficiaries who are transitioning into a permanent supportive housing unit, including those transitioning from institutions, to secure their own housing or provide assistance at any time the beneficiary's housing is placed at risk (e.g., eviction, loss of roommate or income). This service includes the following components:

1. Conducting a housing assessment that identifies the beneficiary's preferences related to housing (type and location of housing, living alone or living with someone else, accommodations needed, and other important preferences), and identifying the beneficiary's needs for support to maintain housing, including the following:
  - a. Access to housing;
  - b. Meeting the terms of a lease;
  - c. Eviction prevention;
  - d. Budgeting for housing/living expenses;
  - e. Obtaining/accessing sources of income necessary for rent;
  - f. Home management;
  - g. Establishing credit; and
  - h. Understanding and meeting the obligations of tenancy as defined in the lease terms.
2. Assisting the beneficiary to view and secure housing as needed. This may include the following:
  - a. Arranging or providing transportation;

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- b. Assisting in securing supporting documents/records;
  - c. Assisting in completing/submitting applications;
  - d. Assisting in securing deposits; and
  - e. Assisting in locating furnishings.
- 3. Developing an individualized housing support plan based upon the housing assessment that meets the following criteria:
  - a. Includes short and long-term measurable goals for each issue;
  - b. Establishes the beneficiary's approach to meeting the goal(s); and
  - c. Identifies where other provider(s) or services may be required to meet the goal(s).
- 4. Participating in the POC development and incorporating elements of the housing support plan;
- 5. Looking for alternatives to housing if permanent supportive housing is unavailable to support completion of transition; and
- 6. Communicating with the landlord or property manager regarding the beneficiary's disability, accommodations needed, and components of emergency procedures involving the landlord or property manager.

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

**Housing Stabilization Services**

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

- 1. Participating in the POC renewal and updates as needed to incorporate elements of the housing support plan;

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2. Providing supports and interventions per the individualized housing support plan. If additional supports or services are identified as needed outside the scope of housing stabilization services, the needs must be communicated to the support coordinator;
3. Providing ongoing communication with the landlord or property manager regarding the following:
  - a. Beneficiary's disability;
  - b. Accommodations needed; and
  - c. Components of emergency procedures involving the landlord or property manager.
4. Updating the housing support plan annually or as needed due to changes in the beneficiary's situation or status.

**Service Exclusions**

These services are only available upon referral from the support coordinator and are not duplicative of other waiver services, including support coordination. These services are only available to beneficiaries who are residing in, or who are linked for the selection process of, a State of Louisiana PSH unit.

**Service Limitations**

Up to 96 units of housing transition or crisis intervention service can be used per POC year without written approval from the support coordinator.

No more than 168 units of combined housing transition or crisis intervention services and housing stabilization services can be used per POC year without written approval from the support coordinator.

**Assistive Technology**

The assistive technology service is time limited, non-recurring and provides both an electronic device and an associated set-up visit to increase a beneficiary's access and participation in activities occurring within their home and the community. Devices purchased through the assistive technology service assist the participant in meeting POC goals, increasing communication, Electronic Visit Verification (EVV) compliance, personal and professional interactions, leisure



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activities, outreach, and access to resources, support and medical care. The assistive technology service allows beneficiaries to purchase a device not otherwise covered by the Medicaid State Plan and receive a one-on-one face-to-face visit to set up and use the device.

The AT service is comprised of the following mandatory components:

1. Electronic tablet device with internet capability that enable beneficiaries to:
  - a. Perceive, control, or communicate within or outside of the beneficiary's residence; and
  - b. Increase access to services, resources and emergency response.
2. Screen protector and a case for the device designed to protect the item from damage; and
3. One-time set-up visit which includes:
  - a. Delivery of the device;
  - b. Device set-up and utilization; and
  - c. In-person education and support provided directly to the beneficiary and/or the beneficiary's natural supports, responsible or legal representative, staff, or others that aid the beneficiary in the use of assistive technology equipment and set-up.

The identified need and how the needs will be addressed with the AT must be included in the POC or POC Revision.

**NOTE: For the beneficiary to receive AT service, they must have internet service in the home.**

**This waiver service is funded through ARPA funds and is NOT deducted from the beneficiary's annual POC budget.**

**Service Exclusions**

AT does not include:

1. Cost or reimbursement for an internet or data plan; and

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2. Cost or reimbursement for repair or replacement of purchased devices or protective cases.

**Service Limitations**

There is a one-time lifetime maximum payment device/item(s) limit per beneficiary.

There is a one-time lifetime maximum procurement/set-up visit limit per beneficiary.

Services must be prior approved by OAAS or its designee and require PA.

Services must be based on a verified need of the beneficiary and the service must have a direct or remedial benefit with specific goals and outcomes. Devices must meet applicable standards of manufacture, design, and capability. The items must be on the POC developed by the support coordinator and are subject to approval by OAAS or its designee.

The purchaser for these items may be the beneficiary, the responsible representative, the direct service provider, the support coordination agency, or any other source. However, the support coordination agency is the **ONLY** source that can bill for these services.

**This waiver service is not subject to the beneficiary's annual POC maximum allotment.**

**Financial Management Services**

Financial Management Services (FMS) assists the beneficiary to live independently in the community while controlling their services by choosing the staff who work with them.

FMS are provided to beneficiaries who have chosen and are capable of self-directing their CCW PAS.

FMS are provided by a Medicaid enrolled F/EA and the F/EA's responsibilities and standards for participation are identified in LAC 50: Part XXI. Chapter 11, Subchapters A. through C.

**Hospice and Waiver Services**

Beneficiaries who elect hospice services may choose to elect CCW and hospice services concurrently. The hospice provider and support coordination agency must coordinate CCW and hospice services when developing the beneficiary's POC. All core hospice services must be provided in conjunction with CCW services.

When electing both services, the hospice provider must develop the POC with the beneficiary, the

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beneficiary's care giver and the support coordination agency. The POC must clearly and specifically detail the CCW and hospice services that are to be provided along with the frequency of services by each provider to ensure that services are non-duplicative, and the beneficiary's daily needs are being met. This will involve coordinating services where the beneficiary may receive services each day of the week.

The hospice provider must be licensed by LDH-Health Standards Section (HSS) and must provide all hospice services as defined in 42 CFR Part 418 which includes nurse, physician, hospice aide/homemaker services, medical social services, pastoral care, drugs and biologicals, therapies, medical appliances and supplies, and counseling in accordance with hospice licensing regulations.

Once the hospice program requirements are met, then CCW PAS can be utilized for those personal care tasks with which the beneficiary requires assistance.

CCW services that have a personal care component associated with the service and are paid at a daily rate (e.g. MIHC, etc.) **CANNOT** be provided and billed on the same day as hospice services.

**Waiver Services Payable While in a Nursing Facility**

Certain CCW services are payable when transitioning from a nursing facility or for a beneficiary during a temporary stay in a nursing facility. (See Appendix F for a complete list of the CCW services).