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 "recipient", this includes that person's responsible representative, legal guardian(s) and/or family member(s), as applicable, who are assisting that person in obtaining services.

NOTE: Recipients 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 designed to assist recipients in 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. The core elements of support coordination include the following:

- Intake;
- Assessment;
- Plan of care development and revision;
- Linkage to direct services and other resources;
- Coordination of multiple services among multiple providers;
- Monitoring/follow-up;
- Reassessment;
- Evaluation and re-evaluation of level of care and need for waiver services;
- Ongoing assessment and mitigation of health, behavioral and personal safety risk;
- Responding to recipient crisis;
- Critical incident management; and
- Transition/discharge and closure.

Support coordination agencies shall also be responsible for assessing, addressing and documenting delivery of services, including remediation of difficulties encountered by recipients in receiving direct services.

Support coordination agencies shall not refuse to serve, or refuse to continue to serve, any individual who chooses/has chosen their agency unless there is documentation to support an inability to meet the individual's health and welfare needs, or all previous efforts to provide 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 recipients' service providers.

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

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

Standards

Support coordination agencies must be:

- Certified by the Louisiana Department of Health (LDH) to operate a support coordination agency;
- Meet the requirements as set forth in the rule for OAAS Home and Community-Based Services Waivers, Support Coordination Standards for Participation;
- Sign a performance agreement with OAAS;
- Assure staff attends all training mandated by OAAS;
- Enroll as a Medicaid provider of support coordination services in all of the regions in which it intends to provide services;

- Comply with all LDH and OAAS policies and procedures; and
- Be listed on the Support Coordination Agency Freedom of Choice (FOC) form.

Reimbursement

Support coordination is reimbursed at an established monthly rate. The data contractor issues a monthly authorization to the support coordination agency. After the support coordination requirements are met and documented in the case management database, the authorization is released to the support coordination agency. For each quarter in the recipient's plan of care (POC) year, if the support coordination agency does not meet all of the requirements for documentation in the case management database the prior authorization (PA) for the last month of that quarter will not be released until all requirements are met. A unit of service is one month.

Transition Intensive Support Coordination (TISC)

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.

Support coordinators shall comply with all the requirements described above under the "Support Coordination" Section. Support coordinators shall initiate and oversee the process for assessment and reassessment, as well as be responsible for ongoing monitoring of the provision of services included in the recipient's approved POC. (See Appendix F for a complete list of the CCW services available during the transition process.)

Standards

Support coordination agencies that provide TISC must be:

- Certified by LDH to operate a support coordination agency;
- Meet the requirements as set forth in the rule for OAAS Home and Community-Based Services Waivers, Support Coordination Standards for Participation;
- Sign a performance agreement with OAAS;
- Assure staff attends all training mandated by OAAS;
- Enroll as a Medicaid provider of support coordination services in all regions in

which it intends to provide services;
- Comply with all LDH and OAAS policies and procedures; and
- Be listed on the Support Coordination Agency FOC form.

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 six months from the POC approval date. Reimbursement is contingent upon the support coordinator 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.

Reimbursement

TISC is reimbursed at a monthly rate as set by Medicaid for a maximum of six months from the POC approval date prior to the date of transition. Payment will not be authorized until the data contractor receives an approved POC indicating that the individual was/is a nursing facility resident during the time period in which prior authorization is requested.

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 are transitioning from a nursing facility to their own living arrangement in a private residence where the individual is directly responsible for his/her 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 LDH and OAAS policies and procedures.

Transition services include the following:

- Security deposits that are required to obtain a lease on an apartment or house;
- Specific set-up fees or deposits for:
    - Telephone;
    - Electricity;
    - Gas;
    - Water; and
    - Other such necessary housing start-up fees or deposits.
- Essential furnishings to establish basic living arrangements:
    - Living Room – sofa/love seat, chair, coffee table, end table and recliner;
    - Dining Room – dining table and chairs;
    - Bedroom – bedroom set, mattress/box spring, bed frame, chest of drawers; nightstand, comforter, sheets, pillows, lamp and telephone;
    - 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;
    - Bathroom – towels, hamper, shower curtain and bath mat;
    - Miscellaneous - window coverings, window blinds, curtain rod, washer, dryer, vacuum cleaner, air conditioner, fan, broom, mop, bucket, iron and ironing board; and
    - Moving Expenses – moving company and cleaners (prior to move, onetime expense).
- Health and welfare assurances:
    - Pest control/eradication;
    - Fire extinguisher;
    - Smoke detector; and
    - First aid supplies/kit.

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

Standards

Support coordination agencies that provide transition services must be:

- Certified by LDH to operate a support coordination agency;
- Meet the requirements as set forth in the rule for OAAS Home and Community-Based Services Waivers, Support Coordination Standards for Participation;
- Sign a performance agreement with OAAS;
- Assure staff attends all training mandated by OAAS;
- Enroll as a Medicaid provider of support coordination services in all regions in which it intends to provide services;
- Comply with all LDH and OAAS policies and procedures; and
- Be listed on the Support Coordination Agency FOC form.

Service Exclusions

Transition services do not include the following:

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

These services 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 individual. Services must be prior approved by the

OAAS Regional Office or its designee and require PA.

NOTE: This is the only waiver service that is not subject to the individual's annual POC maximum cost.

When the individual 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 individual.

The purchaser for these items may be the recipient, 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.

Reimbursement

Payment shall not be authorized until the OAAS Regional Office, or its designee, gives final POC approval upon receipt of the "Decision Notice" form from the Medicaid office.

When the final approval is issued, the data contractor is notified to set up a transition service expense tracking record in the database for the recipient and to release the authorization. The support coordination agency is notified of the release of the authorization and can bill the Medicaid fiscal intermediary for these expenses. If the support coordination agency did not initially pay for the pre-approved transition expenses, the support coordination agency shall reimburse the actual purchaser within ten calendar days of receipt of reimbursement.

The OAAS Regional Office or its designee shall maintain documentation, including each individual's "OAAS Transition Services Form (TSF)" with original receipts and copies of canceled checks, as record of payment to the purchaser(s). This documentation is for accounting and monitoring purposes. (See Appendix B for information about this form.)

Billing for transition services must be completed within 60 calendar days after the individual's actual move date in order for the reimbursement to be paid.

NOTE: If the individual is not approved for CCW services and/or does not transition, but transition service items were purchased, the OAAS Regional Office must notify the OAAS state office to allow for possible reimbursement.

If it is determined that additional items are needed after the TSF was approved, and there are remaining transition funds in the individual's budget, the support coordinator must submit another TSF within 90 calendar days after the individual's actual move date. The same procedure outlined above shall be followed for any additional needs.

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 recipient, or enable the recipient to function with greater independence in the home. Without these necessary adaptations, the recipient would require institutionalization.

NOTE: Necessity is determined when all options (e.g., durable medical equipment, assistive technology, etc.) have been explored and exhausted, or found to be ineffective for justifiable reasons.

There must be an identified need for an environmental accessibility adaptation as indicated by the interRAI Home Care Assessment.

All costs associated with the EAA service (e.g., initial home evaluation also referred to as the Basic Assessment, final inspection, costs of durable medical equipment (DME), costs of construction, etc.) are subject to the participant's annual budget allotment.

If the recipient 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 evaluation report must be reviewed by the OAAS Regional Office 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 he 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 home evaluation 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.

Environmental accessibility adaptations include the following:

- Ramps:
    - Portable; and
    - Fixed;
- Lifts:
    - Porch;
    - Stair;
    - Hydraulic;
    - Manual; and
    - Electronic;
- Modifications of bathroom facilities:
    - Roll shower;
    - Sink;
    - Bathtub;
    - Toilet; and
    - Plumbing;
- Additions to bathroom facilities:
    - Roll shower;
    - Water faucet controls;
    - Floor urinal;
    - Bidet; and
    - Turnaround space;
- Specialized accessibility/safety adaptations/additions:
    - Door widening;
    - Electrical wiring;
    - Grab bars;
    - Handrails;
    - Automatic door opener/doorbell;
    - Voice activated, light activated, motion activated and electronic devices;
    - Fire safety adaptations;

- Medically necessary air filtering device*;
- Medically necessary heating/cooling adaptations*; and
- Other modifications to the home necessary for medical or personal safety.

***A 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 Regional Office, or its designee, and must maintain the documentation in the recipient's records.**

Standards

All EAA assessors and providers must meet the requirements outlined in Section 7.6 – *Provider Requirements* of this manual chapter.

All modifications, adaptations, additions or repairs must be made in accordance with all of the local and state housing and building codes, and must meet the Americans with Disabilities Act requirements.

Environmental accessibility adaptations shall be authorized only if the recipient's health and welfare can be reasonably assured for the duration of the POC year within their remaining resource allocation.

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:

- General house repairs;
- Flooring (carpet, wood, vinyl, tile, stone, marble, etc.);
- Interior/exterior walls not directly affected by an adaptation;
- Lighting or light fixtures that are for non-medical use;
- Furniture;
- Vehicle adaptations;

- Roofing, initial or repairs. This also includes covered ramps, walkways, parking areas, etc.;
- Exterior fences or repairs made to any such structure;
- Motion detector or alarm systems for security, fire, etc.;
- Fire sprinklers, extinguishers, hoses, etc.;
- Smoke, fire and carbon monoxide detectors;
- Interior/exterior non-portable oxygen sites;
- 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;
- Appliances (washer, dryer, stove, dishwasher, vacuum cleaner, etc.);
- Any service covered by the Medicaid State Plan; or
- Any equipment or supply covered by Medicaid's 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 recipient in making a PA request with a DME provider.

Service Limitations

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

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

Reimbursement

Environmental accessibility adaptation services shall be billed for the amount authorized. The EAA assessor must approve the completion of the modification prior to the provider submitting billing. If for some reason the EAA assessor is unable to perform this function, the OAAS Regional Office must provide approval prior to the provider submitting billing.

Personal Assistance Services

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

- Supervision or assistance in performing activities of daily living (ADLs);
- Supervision or assistance in performing instrumental activities of daily living (IADLs);
- Protective supervision solely to assure the health and welfare of the recipient;
- Supervision or assistance with health-related tasks;
- Supervision or assistance while escorting/accompanying the recipient 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
- Extension of therapy services, defined as:
    - 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 recipient in follow-up therapy sessions; and
    - Performance of basic interventions by an attendant who has been instructed by a registered nurse 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 recipients during the course of providing PAS. If transportation is furnished, the provider must accept all liability for their employee transporting a recipient. It is the responsibility of the provider to ensure that the employee has a current, valid driver's license and automobile liability insurance.

PAS is provided in the recipient's home or can be provided in another location outside of the recipient's home if the provision of these services allows the individual to participate in normal life activities pertaining to the ADLs and IADLs cited in the POC. IADLs may not be performed in the recipient's home when the recipient is absent from the home. There shall be no

duplication of services. PAS may not be provided while the recipient is attending or admitted to a program or setting which provides in-home assistance with ADLs or IADLs or while attending or admitted to a program or setting where such assistance is provided. In cases where a recipient goes to the Emergency Room, the PAS worker may provide assistance up until the time the recipient is admitted to the hospital.

The provision of PAS services outside of the recipient's home does not include trips outside of the borders of the state without prior, written approval by OAAS or its designee, through the POC or otherwise. The recipient's written request must include a detailed explanation sent 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 recipient's preferences and personal schedule and OAAS's documentation requirements when the following guidelines are met.

- The approved allocation must be used in accordance with the recipient's preferences within a single, specific prior authorization period.
- Unused portions of the prior authorized allocation may not be saved or borrowed from one prior authorized period to another.
- Total hours used may not exceed the prior authorized period amount.
- Variations from the approved POC in accordance with the recipient's preference must be documented by the direct service/support worker (DSW) on the designated service log. (See Section 7.7 – *Record Keeping* of this manual chapter)
- The **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

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

- Eating:
    - Verbally reminding the recipient to eat;
    - Cutting food into bite-size pieces;
    - Assisting the recipient with feeding; and/or

- Assisting the recipient with adaptive feeding devices (not to include tube feeding unless the DSW has received the required training pursuant to R.S. 37:1031-1034);

- Bathing:
  - Verbally reminding the recipient to bathe;
  - Preparing the recipient's bath;
  - Assisting the recipient with dressing and undressing; or
  - Assisting the recipient with prosthetic devices;

- Dressing:
  - Verbally reminding the recipient to dress;
  - Assisting the recipient with dressing and undressing; or
  - Assisting the recipient with prosthetic devices;

- Grooming:
  - Verbally reminding the recipient to groom;
  - Assisting the recipient with shaving, applying make-up, body lotion or cream;
  - Brushing or combing the recipient's hair;
  - Brushing the recipient's teeth; or
  - Other grooming activities;

- Transferring:
  - Assisting the recipient with moving body weight from one surface to another, such as moving from a bed to a chair; or
  - Assisting the recipient with moving from a wheelchair to a standing position;

- Ambulation:
  - Assisting the recipient with walking (regardless of assistive device); or
  - Assisting the recipient with wheelchair use; and

- Toileting:
    - Verbally reminding the recipient to toilet;
    - Assisting the recipient with bladder and/or bowel requirements, including bedpan routines and changing incontinence pads or adult briefs, if required; or
    - Draining/emptying a catheter or ostomy bag is allowed, but this is not to include removing or changing bags or tubing, inserting, removing and sterilizing irrigation of catheters.

Supervision or Assistance with IADLs

Recipients 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 recipient, not the housekeeping needs of the recipient's household.** Assistance or support with IADLs includes the following:

- Light housekeeping;
    - Vacuuming and mopping floors;
    - Cleaning the bathroom and kitchen;
    - Making the recipient's bed; or
    - Ensuring pathways are free from obstructions;
- Food preparation and food storage as required specifically for the recipient;
- Shopping (with or without the recipient) for items specifically for the recipient such as:
    - Groceries;
    - Personal hygiene items;
    - Medications; or
    - Other personal items;
- Laundry of the recipient's clothing and bedding;

- Medication reminders with self-administered prescription and non-prescription medication that is limited to:

  - Verbal reminders;
  - Assistance with opening the bottle or bubble pack;
  - Reading the directions from the label;
  - Checking the dosage according to the label directions; or
  - 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 R.S. 37:1031-1034.

- Assistance with scheduling (making contacts and coordinating) medical appointments including, but not limited to appointments with:

  - Physicians;
  - Physical therapists;
  - Occupational therapists; and
  - Speech therapists;

- Assistance in arranging medical transportation depending on the needs and preferences of the recipient with:

  - Medicaid emergency medical transportation;
  - Medicaid non-emergency medical transportation;
  - Public transportation; and
  - Private transportation; and

- Accompany the recipient to medical appointments and provide assistance throughout the appointment.

Protective Supervision

Protective supervision may be provided to assure the health, welfare and maintenance of a recipient who has cognitive or memory impairment or who has physical weakness as defined by the OAAS comprehensive assessment.

Supervision or Assistance with Health-Related Tasks

Supervision or assistance with health-related tasks, as specified in the POC, may be provided to recipients (any health related procedures governed under the Nurse Practice Act where the direct service worker has received the required training pursuant to 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 recipients while escorting or accompanying the recipient 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 recipient in follow-up therapy sessions to reinforce and aid the recipient in the rehabilitative process. The attendant may also be instructed by a registered nurse to perform basic interventions with the recipient 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 registered nurses must be documented.

Shared Personal Assistance Services

PAS may be provided by one worker for up to three CCW recipients who live together and have a common direct service provider (DSP).

Waiver recipients may share PAS staff when agreed to by the recipients and the health and welfare of each can be reasonably assured. Shared PAS is to be identified in the approved POC of each recipient. Reimbursement rates are adjusted accordingly. Due to the requirements of privacy and confidentiality, recipients who choose to share these services must agree to sign a confidentiality consent form to facilitate the coordination of services.

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 recipient 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 recipient solely due to the type of PAS delivery method that is listed on the POC.

Standards

Providers must be licensed by the Health Standards Section (HSS) as a personal care attendant or a home health provider, comply with LDH rules and regulations, and be listed as a provider of choice on the FOC form before being approved to provide services.

A home health agency's DSW who renders PAS must be a qualified home health aide as specified in Louisiana's *Minimum Standards for Home Health Agencies* licensing regulations.

PAS providers must develop an individualized back-up staffing plan and agreement. This plan is used when the recipient's assigned PAS worker is unable to provide support due to unplanned circumstances including but not limited to emergencies which arise during a shift. The individualized plan and agreement shall be developed and maintained in accordance with OAAS policy. If the provider cannot meet the recipient's needs, the provider must submit "good cause" reasons to the OAAS Regional Office.

PAS providers shall ensure timely completion of the "OAAS Emergency Plan" for each waiver recipient they serve in accordance with OAAS Policy. (See Appendix B for information on accessing this form.)

Service Exclusions

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

PAS may not be billed at the same time of service as Adult Day Health Care (ADHC) and Caregiver Temporary Support services.

The following individuals are prohibited from being reimbursed for providing services to a recipient:

- The recipient's spouse;
- Recipient's curator;
- Recipient's tutor;
- Recipient's legal guardian;
- Recipient's responsible representative; or

- The person to whom the recipient has given representative and mandate authority (also known as power of attorney).

Recipients are not permitted to receive PAS while living in a home or property owned, operated, or controlled by an owner, operator, agent, or employee of a licensed provider of long-term care services and providers are prohibited from providing and billing for services under these circumstances. Recipients may not live in the home of a direct support worker unless the direct support worker is related by blood or marriage to the recipient (see link for "Who Can Be a Direct Support Worker (DSW flowchart) for PAS and LT-PCS?" in Appendix B of this manual chapter). These provisions may be waived with prior written approval by OAAS or its designee on a case-by-case basis.

Service Limitations

Services must be approved by the OAAS Regional Office or its designee and be prior authorized. In order to bill for these services, the DSW must be with the recipient, be awake, alert and available to respond to the recipient's immediate needs.

Assistance or support with ADL tasks shall not include teaching a family member or friend how to care for a recipient who requires assistance with any ADL.

The provision of PAS services outside of the recipient's home does not include trips outside of the borders of the state without prior written approval of OAAS or its designee, through the POC or otherwise. The recipient's written request must include a detailed explanation and be sent to OAAS, or its designee, at least 24 hours prior to the anticipated travel, when applicable.

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

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

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

Recipients receiving shared PAS must each be:

- Approved to receive CCW;
- Share the same residence; and

- Have a common DSP.

Shared PAS cannot be billed on behalf of a recipient 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.

Reimbursement

Payment shall not be authorized until the OAAS Regional Office or its designee gives final POC approval. When all requirements are met, the support coordinator provides a copy of the approved POC to the recipient and DSP. The DSP is notified of the release of the PA and can bill the Medicaid fiscal intermediary for services provided.

Prior authorization for direct service provider agencies is based on a weekly cap and is released on a daily basis. Unused portions of the prior authorized weekly allotment may not be saved or borrowed from one week for use in another week.

Providers who are approved to provide services to more than one recipient under shared personal assistance services must bill separately for each recipient based on his/her POC. The recipient must be present to receive the service in order for the provider to bill for the service.

Shared and unshared PAS must be billed in 15 minute increments.

"A.m./p.m." PAS must be billed per visit.

Adult Day Health Care Services

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

An ADHC center shall, at a minimum, furnish the following services:

- Assistance with ADLs;
- Health and nutrition counseling;
- Individualized exercise program;
- Individualized, goal-directed recreation programs;
- Health education;
- Medical care management;
- One nutritionally-balanced hot meal and a minimum of two snacks served each day;

  NOTE: A provider may serve breakfast in place of a mid-morning snack Also, providers must allow flexibility with their food and dining options to reasonably accommodate participants' expressed needs and preferences.

- Individualized health/nursing services that include the following:
  - Monitoring vital signs appropriate to the diagnosis and medication regimen of each recipient no less frequently than monthly;
  - Administering medications and treatments in accordance with physicians' orders;
  - Developing and monitoring the individualized medication self-administration plans for each recipient;
  - Serving as a liaison between the recipient and medical resources including the treating physician.

  NOTE: All nursing services shall be provided in accordance with acceptable professional practice standards.

- Transportation between the recipient's place of residence and the ADHC in accordance with licensing standards.
  - The cost of transportation is included in the rate paid to providers of ADHC services. The recipient and his/her family may choose to transport

the recipient to the ADHC center. Transportation provided by the recipient's family is not a reimbursable service;

NOTE: If transportation services are prescribed in any recipient's approved ISP and are not provided by the ADHC center, the center's reimbursement rate shall be reduced accordingly.

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

Standards

Providers must be licensed by HSS as an ADHC provider, enrolled in Medicaid as an ADHC provider, and must be listed as a provider on the FOC form prior to providing ADHC services. ADHC providers must comply with LDH rules and regulations,

ADHC centers are expected to provide transportation to any recipient within their licensed region.

Service Exclusions

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

ADHC service may not be billed at the same time of service as PAS and caregiver temporary support service.

Service Limitations

These services must be provided in the ADHC center that has been selected by the recipient.

ADHC services may be provided no more than 10 hours per day and no more than 50 hours per week (exclusive of transportation time to and from the ADHC center).

Reimbursement for this service requires PA.

Reimbursement

Payment will not be authorized until the OAAS Regional Office or its designee gives final POC approval.

OAAS Regional Office, or its designee, reviews all documents to ensure all requirements are met. If all requirements are met, the support coordinator provides a copy of the approved POC to the recipient and ADHC provider. The ADHC provider is notified of the release of the PA and can bill the Medicaid fiscal intermediary for services provided.

ADHC services must be billed in 15 minute units.

The use of the Electronic Visit Verification (EVV) system is mandatory for ADHC Services. The EVV system requires use of the Louisiana Services Reporting System (LaSRS®) or another EVV system approved by BHSF and OAAS. The system is to be used to electronically "check in" and "check out" waiver recipients when they arrive and when they leave the ADHC center.

The transportation component of ADHC is exempt from this EVV mandatory requirement. However, using the EVV system to electronically record when recipients get on/off the ADHC transportation vehicle may be beneficial to the provider in preventing overlaps with other services and in completing cost reporting.

In the event of an overlap, the provider that uses the EVV system correctly (i.e., data has not been manually added or edited will receive priority for payment.

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 recipient. The purpose of caregiver temporary support is to provide relief to unpaid caregivers or principal caregivers of recipients who receive monitored in-home caregiver services to maintain the recipient's informal support system. Federal financial participation is not claimed for the cost of room and 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:

- The recipient's home or place of residence;
- Nursing facilities;
- Assisted living facilities;
- Respite centers; or
- ADHC centers.

Caregiver temporary support service may be provided in the recipient's home by a Medicaid enrolled PCA or home health agency.

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

Caregiver temporary support service that is provided by an ADHC center may not be provided for more than ten hours per day.

Standards

Providers must comply with LDH rules and regulations and be listed as a provider of choice on the FOC form as a caregiver temporary support provider prior to providing service.

Providers meet the following licensure requirements and Medicaid enrollment requirements:

Provider	Licensure and Enrollment Requirements
Respite Center	Respite Center license and Enroll as a Respite Center provider with applicable sub-specialty
Assisted Living Center	Assisted Living Center license and Enroll as a Caregiver Temporary Support provider with applicable sub-specialty
Adult Day Health Care	Adult Day Health Care license and Enroll as a Caregiver Temporary Support provider with applicable sub-specialty
Nursing Facility	Nursing Facility license and Enroll as a Caregiver Temporary Support provider with applicable sub-specialty
PCA Agency	Personal Care Attendant license and Enroll as a Waiver Personal Care Attendant with applicable sub-specialty
Home Health Agency	Home Health Agency license and Enroll as a Home Health Agency with applicable sub-specialty

Service Exclusions

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

Service Limitations

These services must be prior approved by the OAAS Regional Office 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.

Reimbursement

Payment will not be authorized until the OAAS Regional Office or its designee gives final POC Approval.

For providers of overnight center-based services, the PA start date will be the morning after the first night of service, and the prior authorization end date will be the morning after the last night of service.

Caregiver temporary support service must be billed as follows:

Type of Provider	Billing Units
Waiver PCA Home Health ADHC	15 minute unit of service
Respite Care Centers Assisted Living Centers Nursing Facilities	Daily unit of service

Monitored In-Home Caregiving Services

Monitored in-home caregiving (MIHC) services are services provided to a recipient living in a private home with a principal caregiver. This service provides a community-based option of continuous care, supports, and professional oversight by promoting a cooperative relationship between the recipient, principal caregiver, professional staff of a MIHC agency provider, and the recipient's support coordinator.

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

- Supervision or assistance in performing ADLs;
- Supervision or assistance in performing IADLs;
- Protective supervision provided solely to assure the health and welfare of a recipient;
- 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;
- Supervision or assistance while escorting/accompanying the recipient outside of the home to perform tasks, including instrumental ADLs, 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
- 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.

Standards

Monitored in-home caregiving providers must comply with LDH rules and regulations and be listed as a provider of choice on the FOC form as a MIHC services provider before being approved to provide services. Monitored in-home caregiving providers:

- Must be agency providers who employ professional nursing staff and other professionals to train and support caregivers to perform the direct care activities performed in the home;
- Must assess and approve the home in which services will be provided;
- Shall enter into contractual agreements with caregivers who they have approved and trained; and
- Must pay per diem stipends to caregivers.

Agency providers capture daily notes electronically to monitor the recipient's health and the

caregiver's performance. The daily notes must be available to support coordinators and LDH upon request.

Service Exclusions

Unless the individual is also the spouse of the recipient, the following individuals are prohibited from being reimbursed as a MIHC principal caregiver:

- The recipient's curator;
- The recipient's tutor;
- The recipient's legal guardian;
- The recipient's responsible representative; or
- The person to whom the recipient has given representative and mandate authority (also known as power of attorney).

Limitations

Recipients electing monitored in-home caregiving services are not eligible to receive the following CCW services during the period of time that the recipient is receiving MIHC services:

- Personal assistance services;
- Adult day health care services; or
- Home delivered meal services.

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

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. The recipient's written request must include a detailed explanation sent to OAAS or its designee at least 24 hours prior to the anticipated travel, when applicable.

Reimbursement

Payment will not be authorized until the OAAS Regional Office or its designee gives final POC approval.

Reimbursement is based upon a two-tiered model that is designed to address the recipient's acuity.

Assistive Devices and Medical Supplies

Assistive devices and medical supplies are specialized medical equipment and supplies which include devices, controls, appliances or nutritional supplements specified in the POC that enable recipients to increase or maintain their abilities to perform ADLs or to perceive, control, or communicate with the environment in which they live or provide emergency response.

Assistive devices and medical supplies also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of assistive devices, and durable and non-durable medical equipment. This service includes a personal emergency response system (PERS) and other in-home telecommunication and/or computerized monitoring and medication management technology.

This service may also be used for routine maintenance or repair of specialized equipment. Batteries, extended warranties, and service contracts that are cost effective may be reimbursed. This includes medical equipment and necessary medical supplies not available under the State Plan that addresses recipient functional limitations addressed in the POC.

There must be an identified need for the assistive devices and/or medical supplies as indicated by the assessment, POC, and/or other SC documentation.

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

NOTE: Where applicable, recipients must use Medicaid state plan services, Medicare, or other available payers first. The recipient'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)

PERS is an electronic device which enables the recipient 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 recipient or

installed in his/her home.

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

The PERS unit shall be rented from the PERS provider. Billing for this service involves an installation fee and a monthly maintenance fee which includes the cost of maintenance and training the recipient how to use the equipment. The PERS unit must be installed in the recipient's residence. Reimbursement of these services requires PA.

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.

Telecare

Telecare is a delivery of care services to recipients 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:

- Activity and sensor monitoring;
- Health status monitoring; and
- Medication dispensing and monitoring.

Activity and Sensor Monitoring

This service is a computerized system that monitors the recipient's in-home movement and activity for health, welfare and safety purposes. The system is individually calibrated based on the recipient's typical in-home movements and activities. The provider agency is responsible for monitoring electronically-generated information, for responding as needed, and for equipment maintenance. At a minimum, the system shall:

- Monitor the home's points of egress;
- Detect falls;
- Detect movement or the lack of movement;

- Detect whether doors are opened or closed; and
- Provide a push-button emergency alert system.

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

Health Status Monitoring

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

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

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

Billing for this service includes a one-time installation fee that covers the cost of equipment installation and removal. A monthly maintenance fee includes a face-to-face visit by a registered nurse should the collected data warrant a visit.

Should the recipient require additional visits by a registered nurse during the month, those visits must be authorized with approval from the support coordinator and will be paid at the waiver's Nursing Service rates. If the data indicates a potential emergency, the provider may dispatch a nurse without consultation for approval with the support coordinator; however, the support coordinator must be contacted by the next business day to request retroactive approval.

Medication Dispensing and Monitoring

This service assists the recipient by dispensing medication and monitoring medication compliance. A remote monitoring system is individually pre-programed to dispense and monitor the recipient'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

recipient'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.

Standards

Assistive devices and certain medical equipment and supplies providers must:

- Be a licensed home health agency or a DME provider;
- Comply with LDH rules and regulations;
- Be enrolled in Medicaid to provide these services; and
- Be listed as a provider of choice on the FOC form.

PERS providers must:

- Comply with OAAS' standards for participation;
- Be enrolled as the applicable Medicaid provider type; and
- Be listed as a provider of choice on the FOC form.

The PERS provider must install and support PERS equipment in compliance with all of the applicable federal, state, parish and local laws and regulations, as well as meet manufacturer's specifications, response requirements, maintenance records, and recipient education.

PERS devices must meet Federal Communications Commission standards or Underwriter's Laboratory (UL) standards or equivalent standards.

Telecare service providers must meet the following system requirements:

- Be UL listed/certified or have 501(k) clearance;
- Be web-based;
- Be compliant with the requirements of the Health Insurance Portability and

Accountability Act (HIPAA);

- Have recipient specific reporting capabilities for tracking and trending;
- Have a professional call center for technical support based in the United States; and
- Have on-going provision of web-based data collection for each recipient, as appropriate. This includes response to recipient self-testing, manufacturer's specific testing, self-auditing and quality control.

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

Service Exclusions

No experimental items are allowed.

Service Limitations

Services must be pre-approved by the OAAS Regional Office or its designee and be prior authorized.

Services must be based on a verified need of the recipient 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 are done by the appropriate professional, e.g., an occupational therapist, physical therapist, and/or speech/language pathologist, who has 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 Regional Office or its designee.

A recipient will not be able to simultaneously receive telecare activity and sensor monitoring

services and traditional PERS services.

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

Reimbursement

Assistive devices and medical supplies providers may not bill for this service until after the recipient has been approved for the CCW.

Payment shall not be authorized until the OAAS Regional Office or its designee gives final POC approval.

Billing for PERS or telecare services involves an installation fee and a monthly maintenance fee. Only one claim for each month is allowed. Claims may be span-dated at the discretion of the provider. Partial months shall not be billed.

The monthly maintenance fee for all telecare services includes:

- 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;
- Monitoring of recipient-specific service activities by qualified staff;
- Training the recipient and/or the recipient's responsible representative in the use of the equipment;
- Cleaning and storing equipment;
- Providing remote teaching and coaching as necessary to the recipient and/or caregiver(s); and
- Analyzing data, developing and documenting interventions by qualified staff based on information/data reported.

If a recipient who receives PERS or telecare service moves to a different location or changes providers, reimbursement for a second installment is permissible.

Home Delivered Meals

The purpose of home delivered meals is to assist recipients in meeting their nutritional needs in support of the maintenance of self-sufficiency and enhancing their quality of life.

Home delivered meals includes up to two nutritionally balanced meals per day to be delivered to the home of a recipient who is:

- Unable to leave the home without assistance;
- Unable to prepare his/her own meals; and/or
- Has no responsible caregiver in the home.

The home delivered meal is to provide the recipient a minimum of one-third of the current recommended dietary allowance (RDA) as adopted by the United States Department of Agriculture (USDA). The provision of home delivered meals does not provide a full nutritional regimen.

Standards

All in-state providers must meet all of the Louisiana Office of Public Health certification, permit and inspection requirements for retail food preparation, processing, packaging, storage and distribution.

All out-of-state providers must meet retail food preparation, processing, packaging, storage and distribution requirements of the USDA and the state of operation.

All providers must be enrolled in Medicaid and comply with LDH rules and regulations.

Service Limitations

Meals are limited to two per day. It is permissible for recipients to have some meals delivered daily and others delivered in bulk by different providers as long as the maximum of two meals per day is not exceeded.

Reimbursement

Payment shall not be authorized until the OAAS Regional Office or its designee gives final POC approval.

The data contractor will issue annual PAs. The PA will be for a minimum of four meals per week, up to a maximum of 14 meals per week, not to exceed the limit of two meals per day. One unit of service equals one meal.

Providers will be allowed to span date bill for up to a two weeks supply of meals.

Nursing

Nursing services are services that are medically necessary and may be provided efficiently and effectively by a nurse practitioner, registered nurse (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 recipient'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 recipient's fragile or complex medical condition as well as the monitoring of a recipient with a history of noncompliance with medication or other medical treatment needs.

Nursing services may also be used to assess a recipient's need for assistive devices or home modifications, training the recipient 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 recipient and must have a direct or remedial benefit to the recipient with specific goals and outcomes.

Standards

Providers must be enrolled in Medicaid as a nursing provider, comply with LDH rules and regulations, and must be listed as a provider of choice on the FOC form.

Nursing services provided must be within the scope of the Louisiana Statutes governing the practice of nursing.

Nursing services may be provided by a nurse practitioner, an RN or LPN employed by a home health agency.

Service Exclusions

Nursing providers shall not bill for this service until after the recipient has been approved for the CCW.

Nursing services shall not be provided when the recipient is an inpatient at a hospital.

Service Limitations

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

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

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

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

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

Reimbursement

Payment shall not be authorized until the OAAS Regional Office or its designee gives final POC approval.

The data contractor will issue PAs for no more than six months.

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

Skilled maintenance therapy includes physical therapy, occupational therapy, respiratory therapy and/or speech and language therapy that may be received by CCW recipients in their home.

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

Skilled maintenance therapies may also be used to assess a recipient's need for assistive devices

or home modifications, training the recipient 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 recipient's home or in a variety of locations as approved by the POC planning team.

Physical Therapy

Physical therapy 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:

- Professional assessments;
- Evaluations and monitoring for therapeutic purposes;
- Physical therapy treatments and interventions;
- Training regarding physical therapy activities;
- Use of equipment and technologies;
- Designing, modifying or monitoring the use of related environmental modifications;
- Designing, modifying, and monitoring the use of related activities supportive to the POC goals and objectives; or
- Consulting or collaborating with other service providers or family members, as specified in the POC.

Occupational Therapy

Occupational therapy 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:

- Teaching of daily living skills;
- Development of perceptual motor skills and sensory integrative functioning;

- Design, fabrication, or modification of assistive technology or adaptive devices;
- Provision of assistive technology services;
- Design, fabrication, or applying selected orthotic or prosthetic devices or selecting adaptive equipment;
- Use of specifically designed crafts and exercise to enhance function;
- Training regarding occupational therapy activities; and
- 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, facilitate oral motor and swallowing function, facilitate use of assistive technology, and/or prevent progressive disabilities.

Specific services may include:

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

Standards

Skilled maintenance therapy services may be provided by home health agencies that employ licensed therapists and comply with LDH rules and regulations.

Service Exclusions

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

Skilled maintenance therapies shall not be provided when the recipient is an inpatient at a hospital.

Service Limitations

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

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

Providers are not required to have a doctor's order for assessments or treatment/services before this service is reimbursed through the CCW Program; however, providers may be required to have a doctor's order for assessments and treatment/services before this service is reimbursed by other payers.

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

Reimbursement

Payment shall not be authorized until the OAAS Regional Office or its designee gives final POC approval.

A prior authorization period will not exceed six months.

Housing Transition or Crisis Intervention Services and Housing Stabilization Services

These housing support services assist waiver recipients 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 recipients 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 recipient's housing is placed at risk (e.g., eviction, loss of roommate or income). This service includes the following components:

- Conducting a housing assessment that identifies the recipient'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 recipient's needs for support to maintain housing, including:
    - Access to housing;
    - Meeting the terms of a lease;
    - Eviction prevention;
    - Budgeting for housing/living expenses;
    - Obtaining/accessing sources of income necessary for rent;
    - Home management;
    - Establishing credit; and
    - Understanding and meeting the obligations of tenancy as defined in the lease terms.
- Assisting the recipient to view and secure housing as needed. This may include:
    - Arranging or providing transportation;
    - Assisting in securing supporting documents/records;
    - Assisting in completing/submitting applications;
    - Assisting in securing deposits; and
    - Assisting in locating furnishings.
- Developing an individualized housing support plan based upon the housing assessment that:
    - Includes short and long-term measurable goals for each issue;
    - Establishes the recipient's approach to meeting the goal(s); and
    - Identifies where other provider(s) or services may be required to meet the goal(s).
- Participating in the development of the POC and incorporating elements of the

housing support plan;

- Looking for alternatives to housing if permanent supportive housing is unavailable to support completion of transition; and

- Communicating with the landlord or property manager regarding the recipient's disability, accommodations needed, and components of emergency procedures involving the landlord or property manager.

If at any time the recipient'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 recipients to maintain their own housing as set forth in the recipient's approved POC. Services must be provided in the home or a community setting. This service includes the following components:

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

- 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.

- Providing ongoing communication with the landlord or property manager regarding:

    - The recipient's disability;
    - Accommodations needed; and
    - Components of emergency procedures involving the landlord or property manager.

- Updating the housing support plan annually or as needed due to changes in the recipient's situation or status.

Standards

Housing transition or crisis intervention services and housing stabilization services may be provided by permanent supportive housing agencies that are enrolled in Medicaid to provide these services, comply with LDH rules and regulations and are listed as a provider of choice on the FOC form.

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 recipients who are residing in, or who are linked for the selection process of, a State of Louisiana permanent supportive housing 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.

Reimbursement

Payment will not be authorized until the OAAS Regional Office or its designee gives final POC approval.

OAAS Regional Office or its designee reviews all documents to ensure all requirements are met. If all requirements are met, the support coordinator provides a copy of the approved POC to the recipient and the permanent supportive housing provider. The permanent supportive housing provider is notified of the release of the PA and can bill the Medicaid fiscal intermediary for services provided. Services must be billed in 15 minute units.

Hospice and Waiver Services

Recipients who receive waiver services may also be eligible for Medicaid hospice services.

Recipients who elect hospice services may choose to elect Community Choices Waiver (CCW) and hospice services concurrently. The hospice provider and support coordination agency must coordinate CCW and hospice services when developing the recipient's plan of care (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 recipient, the recipient'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 recipient's daily needs are being met. This will involve coordinating services where the recipient may receive services each day of the week.

The hospice provider 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.

Once the hospice program requirements are met, then CCW Personal Assistance Services (PAS) can be utilized for those personal care tasks covered in the CCW program for which the recipient requires assistance.

Waiver Services Payable While in a Nursing Facility

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