COVERED SERVICES

The array of services described below is provided under the New Opportunities Waiver (NOW) in accordance with the plan of care (POC), in addition to all regular Medicaid State Plan services. This person-centered plan is designed cooperatively by the support coordinator, the beneficiary, service providers, and members of the beneficiary's support network, which may include family members, appropriate professionals, and other individuals who best know the beneficiary. The POC should contain all paid and unpaid services that are necessary to support the beneficiary in their home and promote greater independence.

Beneficiaries must receive at least one NOW service every 30 days. **Support coordination is not a covered NOW service.**

Support coordination services includes on-going support and assistance to the beneficiary.

The support coordinator must provide information, assistance, and management of the service being self-directed to beneficiaries that choose to self-direct their waiver services.

Service Limits

Support coordination shall not exceed 12 units. One calendar month constitutes one unit. Virtual visits are permitted; however, the initial and annual POC meeting and at least one other meeting per year must be conducted face-to face. When a relative living in the home or a legally responsible individual or legal guardian provides a paid NOW service, all support coordination visits must be conducted face-to-face, with no option for virtual visits.

Individual and Family Support

Individual and family support (IFS) services are defined as direct support and assistance provided to a beneficiary in their home or in the community that allow the beneficiary to achieve and/or maintain increased independence, productivity, enhanced family functioning, and inclusion in the community to the same degree as individuals without disabilities. IFS services are also used to provide relief to the primary caregiver. IFS services may not supplant primary care available to the beneficiary through natural and community supports.

IFS services include the following allowable activities:

1. Assistance and prompting with personal hygiene, dressing, bathing, grooming, eating, toileting, ambulation or transfers, other personal care and behavioral support needs and any medical task which can be delegated;

2. Assistance and/or training in the performance of tasks related to maintaining a safe, healthy, and stable home, such as:

    a. Housekeeping;

    b. Laundry;

    c. Cooking;

    d. Evacuating the home in emergency situations;

    e. Shopping; and

    f. Money management, which includes paying bills.

3. Assistance in participating in community, health, and leisure activities which may include accompanying the beneficiary to these activities;

4. Assistance and support in developing relationships with neighbors and others in the community and in strengthening existing informal social networks and natural supports;

5. Enabling and promoting individualized community supports targeted toward inclusion into meaningful integrated experiences such as volunteer work and community awareness activities; and

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

The provider is required to utilize the standard POC provider documents specified by Office for Citizens with Developmental Disabilities (OCDD) to identify how the supports will be delivered. Documentation is required of all supports provided to the beneficiary that allows them to meet the goals identified on the approved POC.

Individual and Family Support - Day

Individual and family support – day (IFS – D) services will be authorized during waking hours for up to 16 hours when natural supports are unavailable in order to provide continuity of services to the beneficiary. Waking hours are the period of time when the beneficiary is awake and is not limited to traditional daytime hours as outlined in the approved POC. The IFS worker must be awake, alert, and available to respond to the beneficiary's immediate needs.

Additional hours of IFS – D beyond the 16 hours may be approved based on documented need, which can include medical or behavioral and specified in the approved POC.

Individual and Family Support - Night

Individual and family support – night (IFS – N) services are the availability of direct support and assistance provided to the beneficiary while the beneficiary sleeps. Night hours are considered the period of time when the beneficiary is asleep and there is reduced frequency and intensity of required assistance.

IFS – N services are not limited to traditional night hours and are documented in the approved POC. The number of IFS – N services for beneficiaries who receive less than 24 hours of paid support is based on need and specified in the POC.

The IFS – N worker must be immediately available and in the same residence as the beneficiary to be able to respond to the beneficiary's immediate needs. Documentation of the level of support needed, which is based on the frequency and intensity of needs, must be included in the POC with supporting documentation in the provider's service plan. Supporting documentation shall outline the beneficiary's safety, communication, and response methodology planned for and agreed to by the beneficiary and/or their authorized representative.

The IFS – N worker is expected to remain awake and alert unless otherwise authorized under the procedures noted below:

1. Beneficiaries who are able to notify direct support workers of their need for assistance during sleeping hours;

2. Support team assesses the beneficiary's ability to awaken staff. If it is determined that the beneficiary is able to awaken staff, then the approved POC shall reflect the beneficiary's request that the IFS – N worker be allowed to sleep;

3. Support team should consider the use of technological devices that would enable the beneficiary to notify/awaken IFS – N staff. Examples of devices include wireless pagers, alerting devices such as a buzzer, a bell or a monitoring system. If the method of awakening the IFS – N worker utilizes technological device(s), the service provider will document competency in use of devices by both the beneficiary and IFS – N staff prior to implementation. The support coordinator will require a demonstration of effectiveness of this service on at least a quarterly basis;

4. Review shall include review of log notes indicating instances when IFS – N staff was awakened to attend to the beneficiary and an acknowledgement by the beneficiary that the IFS – N staff responded to their need for assistance timely and

appropriately. Any instance that indicates the staff did not respond appropriately will immediately be brought to the attention of the support team for discontinuing the allowance of the staff to sleep; and

5. Any allegation of abuse/neglect during sleeping hours will result in discontinuing the allowance of the staff to sleep until an investigation is complete. Valid findings of abuse/neglect during night hours will require immediate revision to the POC.

Shared Supports

IFS – D or IFS –N services can be shared by up to three waiver beneficiaries who may or may not live together when the beneficiaries meet the following:

1. Have a common IFS provider agency;

2. Agree to share services; and

3. Assurance is made for each beneficiary's health and safety.

Service can be in the home of a beneficiary or in the community. The direct service worker (DSW) must be present with the beneficiaries, but does not have to be in the same room with all the beneficiaries at the same time. The worker may move freely between rooms or between indoor and outdoor spaces related to the home in order to assist beneficiaries in their choice of activities.

Shared support in a community-based event requires the DSW to maintain proximity with visual and auditory contact, offering hands-on assistance when appropriate. For example, if the worker is with two beneficiaries at the park, the DSW may be tossing a ball with one beneficiary while maintaining visual/auditory contact with another beneficiary who is sitting on a bench.

The decision to share staff must be reflected on the beneficiary's POC and based on an individual-by-individual determination and choice with reimbursement rates adjusted accordingly.

Sharing Supports among Roommates

Finding a beneficiary or beneficiaries to share supports within one's home is based upon the choice and preferences of the beneficiaries involved. Beneficiaries who live together as roommates and who agree to share supports must sign a release of information allowing each beneficiary's name to be used in the POC, progress notes, individualized service plan, etc., of the other beneficiaries with whom services are shared.

The POC for beneficiaries sharing supports among roommates include the following:

1. Completed "Documentation for Authorization of Shared Staff and Release of Information for New Opportunities Waiver (NOW)" form for each beneficiary, (See Appendix D for information on accessing the *Guidelines for Support Planning* found in Section 6 for a copy of this form);

2. POC for each beneficiary that includes the names of the roommates in the "Current Living Situation: Information" section and documentation indicating the risks and benefits of sharing supports has been discussed with the beneficiaries; and

3. Copies of budget sheets and typical weekly schedules of all beneficiaries who will be sharing supports.

NOTE: Budget sheets and POCs must be consistent between the beneficiaries when supports are shared in a shared living setting.

Sharing Supports among Non-Roommates

Beneficiaries who choose to share supports casually (i.e., attend a ballgame, movie, go out to eat together, etc.) are **not** required to sign a release of information form or list the names of the other beneficiaries on the POC. Additionally, the IFS hours can be flexed to allow for casual sharing without a revision to the POC as long as sharing between the beneficiaries is driven by the person and is appropriate. Routine sharing of hours should be budgeted as shared hours in the POC.

Support coordination agencies and IFS provider agencies must follow the policy specified in the *Office for Citizens with Developmental Disabilities* (OCDD) *Guidelines for Support Planning.* (See Appendix D for *Guidelines for Support Planning* information for shared services).

Shared IFS services, hereafter referred to as shared support services, may be either day or night services. In addition, IFS direct support may be shared across the Children's Choice Waiver or the Residential Options Waiver at the same time.

Transportation

Transportation **is included** in the rate paid to the direct service provider with no specified mileage limit. The provider is not allowed to charge the beneficiary, their family member or others a separate fee for transportation.

In the absence of natural or community supports, the provider is responsible for transporting the beneficiary to approved activities as specified in the POC.

The provider is also responsible for providing transportation to unscheduled medical visits required by the beneficiary.

Place of Service

IFS services may be provided in the beneficiary's home or in the community. IFS may **not** be provided in the following locations:

1. Worker's residence, unless the worker's residence regardless of the relationship, is a certified foster care home;

2. Hospital once the beneficiary has been admitted for inpatient services;

3. Licensed congregate setting. A licensed congregate setting includes licensed intermediate care facilities for individuals with intellectual disabilities (ICFs/IID), community homes, center-based respite facilities, and day habilitation programs;

4. Outside the state of Louisiana, but within the United States or its territories, unless there is a documented emergency or a time-limited exception (not to exceed 30 days) which has been prior approved by the local governing entity (LGE) and included in the beneficiary's POC; and

5. Outside the United States or territories of the United States.

   NOTE: Time spent on a cruise ship that leaves and returns to the same United States port of call is eligible for IFS services. Time spent off the cruise ship and in a foreign country or territory is not eligible for IFS services. Tickets for these types of trips should not be purchased until a revision to POC has been approved by the LGE. Beneficiary funds are not allowed to be used to purchase travel tickets for DSWs accompanying the beneficiary on the trip without written approval from the LGE.

Standards

Providers must possess a current, valid home and community-based service (HCBS) providers' license to provide personal care attendant (PCA) services and enroll as a Medicaid provider for waiver services or be a DSW providing support under an authorized self-direction option.

Service Exclusions

Beneficiaries who live in distinct residences may not share in-home supports when the beneficiaries are in their own respective homes. This includes beneficiaries who live next door to each other or live in separate apartments within one complex.

Service Limitations

IFS cannot be billed or provided for during the same hours on the same day as:

1. Day habilitation;
2. Supported employment models;
3. Prevocational services;
4. Transportation for habilitation services;
5. Professional services
6. Center-based respite
7. Skilled nursing services; and
8. Individualized and family support - night/shared.

Additionally, IFS cannot be billed when a beneficiary has been admitted to an in-patient setting, (i.e., hospital, nursing home, psychiatric hospital, etc.). Services can be provided and billed up until the beneficiary is admitted and after the beneficiary is discharged. Documentation from the admitting/discharging facility which documents the time of admit/discharge may be required for services to be reimbursed. See Appendix F for claims filing instructions when a beneficiary has been hospitalized.

The IFS – D or IFS - N worker may not work more than 16 hours in a 24-hour period for a single provider agency unless there is a documented emergency, time limited, non-routine need that is documented in the beneficiary's approved POC, or approved in writing by the OCDD Waiver Director/designee. Habitual patterns of a worker providing more than 16 hours of paid services per day will be investigated.

Unless an exception is documented in the beneficiary's approved POC, IFS – D services **may not** exceed 16 hours per calendar day.

IFS – N services must be a minimum of eight hours for beneficiaries who receive 24 hours of care unless approved by OCDD Central Office and documented in the beneficiary's approved POC.

Beneficiaries cannot receive more than 24 hours of combined IFS – D and IFS – N services within a 24-hour period.

The beneficiary and worker must be present in order for the provider to bill for this service. In no instance should a beneficiary be left alone when services are being provided.

Family members who provide IFS services must meet the same standards as providers or direct care staff who are unrelated to the beneficiary. Each person living in the home can work no more than 40 hours per week, Sunday to Saturday.

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

Authorization for Worker to Exceed 16-Hour Service Limitation

The LGE may approve IFS-D or IFS-N workers to provide services for more than 16 hours in a 24-hour period, which includes a combination of IFS – D and IFS – N services, in the following circumstances:

1. Non-routine, time limited basis when the primary caregiver is unable to provide care to the beneficiary outside the regular IFS hours due to the hospitalization or death of a family member, emergency with another child or family member, business travel, or other documented need. Time limited is defined as one exception per quarter for up to seven calendar days. Any request beyond this limit must obtain approval from the OCDD Central Office; and

2. Emergency situations that could include hurricane, tornado, flooding, or other natural disaster.

Requests must be made by the beneficiary to the support coordinator. Upon notification of the request, the support coordinator is responsible for submitting a revision request to the LGE by the next business day. Requests must include supporting documentation. The OCDD Waiver director /designee can approve a request to exceed the 16-hour rule without a revision to the POC. Examples include a natural disaster affecting wide spread areas of the state (flooding, hurricane, tornado, etc.).

Reimbursement

The service unit is 15 minutes and is reimbursed at a flat rate. (See Appendix E for service procedure code/rate information).

The provider must bill for all beneficiaries who share supports using the appropriate shared supports codes. The billing submission is required to match among beneficiaries served by the provider.

The use of the Electronic Visit Verification (EVV) system is mandatory for individual and family support services. The EVV system requires the electronic check in/out in the Louisiana Services Reporting System (LaSRS®) or another EVV system approved by the Bureau of Health Services Financing (BHSF) and OCDD.

Supplemental Payment for Individuals receiving IFS with Complex Needs

Supplemental payment will provide funds for additional support to individuals currently receiving qualified waiver services who have complex medical and/or behavioral needs, and as a result are at a higher risk of institutionalization due to the inability to access waiver provider services, retain direct support staff, or access other professional services not covered by the waiver. The integration of this supplemental payment provides supports that focus on the prevention of deteriorating or worsening medical or behavioral conditions.

The supplemental payment is intended to be time limited to such an extent that the individual supported is expected to progress and become stable due to the service(s). Once stability is achieved, the supplemental payment will be discontinued.

Process for Determination

A Louisiana approved Medicaid provider must routinely provide a minimum of eight hours of IFS services daily to the individual and must complete a screening tool and submit initial documentation prior to qualifying for any supplemental payment.

The individual cannot receive 12 hours or more of skilled nursing services per day. The supplemental payment is not allowed for waiver participants who do not receive IFS services.

Medical:

1. Individual requires at least two of the following non-complex nursing tasks on a routine basis to be performed by a DSW in accordance with the Direct Service Worker (DSW) Guidelines for Didactic Training. A DSW who has undergone

documented, person-specific training on the delegable non-complex tasks required for this individual will perform the following required tasks:

a. Suctioning of a clean, well-healed, uncomplicated mature tracheostomy in an individual who has no cardiopulmonary problems and is able to cooperate with the person performing the suctions (excludes deep suctioning);

b. Care of a mature tracheostomy site;

c. Removing/cleaning/replacing inner tracheostomy cannula for mature tracheostomy;

d. Providing routine nutrition, hydration, or medication through an established gastrostomy or jejunostomy tube (excludes naso-gastrostomy tube);

e. Clean intermittent urinary catheterization;

f. Obtaining a urinary specimen from a port of an indwelling urinary catheter;

g. Changing a colostomy appliance;

h. Ensuring proper placement of nasal cannula (excludes initiation/changing of flow rate;

i. Capillary blood glucose testing;

j. Simple wound care (including non-sterile/clean dressing removal/application); and

k. Other delegable non-complex tasks as approved by OCDD.

2. Documented evidence that home health/skilled nursing agencies cannot provide the service via other available options such as the Medicaid State Plan.

Behavioral:

1. Individual must meet two of the following:

    a. Specific behavioral programming/procedures are required, or the individual receives behavioral health treatment/therapy and needs staff assistance on a daily basis to complete therapeutic "homework" or use skills/coping mechanism being addressed in therapy;

    b. Staff must sometimes intervene physically with the individual beyond a simple touch prompt or redirect, or the individual's environment must be carefully structured based on professionally driven guidance/assessment to avoid behavior issues or minimize symptoms; and

    c. Supervised period of time away, outside of the individual's weekly routine, is needed at least once per week. This may manifest through the presence of severe behavioral health symptoms on a weekly basis that restrict the individual's ability to work, to go to school, and/or to participate in their community.

2. Due to the above items the individual requires one of the following:

    a. "Higher credentialed" staff (college degree, specialized licensing like registered behavioral technician (RBT), applied behavioral analyst (ABA), etc.), who have advanced behavioral training for working with individuals with severe behavioral health symptoms or significant experience working with this population; and

    b. Need for higher qualified supervision of the direct support of staff (master's degree, additional certification like board certified behavioral analyst (BCBA), etc.) **and** the expertise is not available through other professionals/services.

Documentation requirements are defined in Section 32.8, Record Keeping of this manual chapter.

Center-Based Respite

Center-based respite (CBR) service is temporary short-term care provided to a beneficiary who requires support and/or supervision in their day-to-day life due to the absence or relief of the primary caregiver.

The beneficiary's routine is maintained while receiving CBR service so that they is able to attend school, work, or other community activities and outings. Community outings shall be specified in the beneficiary's approved POC and shall include activities the beneficiary would receive if they were not in CBR care.

Transportation

The CBR provider is responsible for transporting the beneficiary to community outings, such as work, school, etc., as this is included in the service rate. There is no mileage limit specified for this service.

Standards

Providers must possess a current, valid HCBS providers' license to provide respite as a center-based respite facility and enroll as a Medicaid waiver provider.

Service Exclusions

The cost of room and board is not included in the reimbursement paid to the CBR provider.

Service Limitations

CBR services shall not exceed 720 hours (2,880 1/4 hours units) per beneficiary per POC year unless approval is given by OCDD Central Office.

CBR services cannot be provided or billed for during the same hours on the same day as:

1. Day habilitation;
2. Supported employment models;
3. Prevocational services
4. Transportation for habilitation services
5. Professional services
6. Individual and family support–day/night/shared
7. Skilled nursing services, or
8. Community integration and development.

Both the beneficiary and a DSW must be present for the provider to bill for this service.

Reimbursement

The service unit is 15 minutes and is reimbursed at a flat rate. (See Appendix E for service procedure code/rate information).

The use of the EVV system is mandatory for CBR services. The EVV system requires the electronic check in/out in the LaSRS® or another EVV system approved by BHSF and OCDD.

Community Life Engagement Development

Community life engagement development (CLED) should be utilized for the purpose of development of opportunities to assist individuals in becoming involved in their community and helping to develop a meaningful day for each individual. The purpose is to encourage and foster the development of meaningful relationships and memberships in the community, reflecting the person's choices and values:

CLED service:

1. Will be person-centered with an outcome of increased community activities and involvement in areas of interest as expressed by the individual;

2. Should include church involvement, civic involvement, volunteering opportunities, as well as recreational activities; and

3. Should be integrated with the community and not segregated groups.

The role of the CLED should be to develop individual activities, memberships and volunteer positions within the beneficiary's community based off each beneficiary's person centered plan and expressed interests and desires.

Transportation

The cost of transportation is included in the rate paid to the provider.

Service Limitations

CLED services can be billed at the same time that the beneficiary is receiving a day or employment service:

1. Beneficiary may or may not be present;

2. Billed in 15 minute increments;

3. 240 units per POC year (60 hours) which includes the combination of shared and non-shared CLE; and

4. Services shall not exceed the number of units defined in the beneficiary's POC and must be prior authorized.

To utilize this service, the beneficiary may or may not be present as identified in the approved POC.

Residential Habilitation – Supported Independent Living

Residential habilitation – supported independent living (SIL) services assist beneficiaries, aged 18 years or older, to acquire, improve, or maintain social and adaptive skills necessary to enable them to reside in the community and to participate as independently as possible.

SIL services include assistance and/or training in the performance of tasks such as personal grooming, housekeeping, money management and bill paying. SIL services may serve to reinforce skills or lessons taught in school, therapy or other settings. Beneficiaries receiving SIL services have the right to control their personal resources, and are not required to designate the provider agency as their representative payee. This includes payments to beneficiaries from supported employment or other employment sources.

SIL services also assist beneficiaries in obtaining financial aid, housing, advocacy and self-advocacy training as appropriate, emergency support, trained staff, and accessing other programs for which they qualifies.

Payment for this service includes oversight and administration and the development of service plans for the enhancement of socialization with age-appropriate activities that provide enrichment and may promote wellness. The service plan should include initial, introduction, and exploration for positive outcomes for the beneficiary for community integration development.

Place of Service

The setting for SIL services must be integrated in the greater community, and support full access to the community by the beneficiary. If housing assistance is provided, the setting shall be selected from among setting options, including non-disability specific settings, and an option for a private unit. The settings options offered must be documented in the beneficiary's person specific plan of care and be based on the individual's needs, preferences, and resources available, and must allow the right to privacy in their living unit or bedroom. Additionally, the settings must provide protection from eviction through a lease agreement that provides protections that address eviction processes and appeals comparable to the state's landlord tenant law. The residential unit shall have doors lockable by the beneficiary (unless contraindicated due to health and safety and documented in the plan of care) with only appropriate staff having keys to doors. If sharing residential services, the beneficiary shall have choice with whom to share. Beneficiaries will have the freedom to furnish and decorate their sleeping or living units as allowed in the lease/agreement.

Services are provided in the beneficiary's place of residence and/or in the community. The beneficiary's residence includes their apartment or house, not the residence of a legally responsible relative. An exception will be **considered** when the beneficiary lives in the residence of a legally responsible relative who is age 70 or older or who is disabled.

Provider-owned property where services are delivered must be compliant with the Americans with Disabilities Act (ADA) as applicable to the beneficiary's individual needs.

Beneficiaries must be able to choose to receive supports from any provider on the Freedom of Choice list in their region. When an SIL provider owns or leases property to a beneficiary, the provider shall not terminate or refuse to renew a beneficiary's lease based solely on the beneficiary's choice of utilizing another provider for their service delivery. A beneficiary's lease shall not be tied to a provider's service agreement.

NOTE: A legally responsible relative is defined as the parent of a minor child, foster parent, curator, tutor, legal guardian, or the beneficiary's spouse.

SIL services **cannot** be provided in the following settings:

1. Substitute Family Care (SFC) home; or

2. CBR facility.

Standards

Providers must possess a current, valid HCBS providers' license to provide supervised independent living services and enroll as a Medicaid waiver provider.

Service Exclusions

Legally responsible persons may not be SIL providers to the person for whom they have legal responsibility. Payment for SIL does not include payments made directly or indirectly to the members of the beneficiary's immediate family.

SIL does not include the cost of the following:

1. Meals or the supplies needed for meal preparation;
2. Room and board;
3. Home maintenance or upkeep and improvement;
4. Routine care and supervision which could be expected to be provided by a family member; or
5. Activities or supervision for which a payment is made by a source other than Medicaid (e.g. OCDD).

Service Limitations

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

No more than three people can live together and share an SIL setting unless they are related or have been granted an exception by the OCDD Assistant Secretary or their designee.

The SIL service is not available to beneficiaries in the self-direction option, as these beneficiaries are responsible for directing their own care.

Reimbursement

The service unit is one per day per POC year and is reimbursed at a flat rate. (See Appendix E for service procedure code/rate information).

The use of the EVV system is mandatory for the monthly face-to-face SIL visit in the home. The EVV system requires the electronic check in/out in the LaSRS® or another EVV system approved by BHSF and OCDD.

Substitute Family Care

Substitute Family Care (SFC) is a stand-alone family living arrangement for beneficiaries, aged 18 years or older, in which the SFC house parents assume the direct responsibility for the beneficiary's physical, social, and emotional well-being and growth, including family ties. The SFC home must meet all licensing requirements for the substitute family care module.

SFC provides beneficiaries who live in an SFC home with the following:

1. Day programming;
2. Transportation;
3. Independent living training;
4. Community integration;
5. Homemaker;
6. Chore;
7. Attendant care and companion services; and
8. Medication oversight (to the extent permitted under state law).

Beneficiaries living in an SFC home may receive IFS and other services through the NOW. The provider is required to prepare POC provider documents for the provision of SFC services based on the beneficiary's approved POC. Beneficiaries receiving SFC services have the right to control their personal resources, and are not required to designate the provider agency or the SFC caregiver as their representative payee. This includes payments to beneficiaries from supported employment or other employment sources. Additionally, beneficiaries have the right to privacy in their living unit or bedroom with doors lockable by the individual unless contraindicated in the POC. If sharing residential services, the beneficiary shall have choice with whom to share. Beneficiaries will have the freedom to furnish and decorate their sleeping or living units.

Standards

Providers must possess a current, valid HCBS providers' license with the substitute family care services module and enroll as a Medicaid waiver provider.

Service Exclusions

SFC services do not include payment for room and board, items of comfort or convenience, facility maintenance, upkeep and improvement, or payments made directly or indirectly to members of the beneficiary's immediate family.

SFC homes shall not be SIL settings.

Service Limitations

Only two SFC beneficiaries can reside in a single SFC setting at the same time. There shall be no more than three persons living in a substitute family care setting who are unrelated to the SFC family. Immediate family members (spouse, mother, father, brother and/or sister) cannot be substitute family care parents. Reimbursement for this service includes the development of a service plan based on the approved POC.

SFC services cannot exceed 365 days per year.

Reimbursement

The service unit is one service per day and is reimbursed at a flat rate. (See Appendix E for service procedure code/rate information).

Day Habilitation

Day habilitation services:

1. Provide beneficiaries, aged 18 years or older, with assistance in developing social and adaptive skills necessary to enable them to participate as independently as possible in the community. Day habilitation services focus on socialization with meaningful age-appropriate activities which provide enrichment and promote wellness.

2. Provided in a variety of community settings, (i.e. local recreation department, garden clubs, libraries, etc.) other than the person's residence and are not limited to a fixed- site facility. Interactions with beneficiaries are expected to be respectful and protect the individual's right of privacy for personal care issues as well as interactions or situations involving any aspect of the individual's care and support.

3. Must be directed by a service plan that has been developed by the provider to address the beneficiary's POC goals, and to provide the beneficiary a choice in how

they spend their day. The activities should assist the beneficiary to gain their desired community living experience, including the acquisition, retention or improvement in self-help, socialization and adaptive skills, and/or to provide the individual an opportunity to contribute to and be a part of his or her community.

4. Must be coordinated with any physical, occupational, or speech therapies, prevocational services or employment listed in the beneficiary's approved POC, and may serve to reinforce skills or lessons taught in school, therapy, or other settings to attain or maintain the beneficiary's maximum functional level. The beneficiary does not receive payment for the activities in which they are engaged.

Some examples of day habilitation services include, but are not limited to, the following:

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

2. Assisting and prompting with personal hygiene, dressing, grooming, eating, toileting, ambulation or transfers, other personal care and behavioral support needs, and any medical task which can be delegated. Personal care assistance may not comprise the entirety of this service;

3. Receiving personal care skills training at a facility to improve their adaptive skills;

4. Participating in a community inclusion activity designed to enhance the beneficiary's social skills;

5. Training in basic nutrition and cooking skills at a community center;

6. Participating, for an older beneficiary, with a group of senior citizens in a structured activity. This may include activities such as community-based activities sponsored by the local Council on Aging (COA);

7. Receiving aerobic aquatics in an inclusive setting to maintain the beneficiary's range of motion;

8. Learning how to clean a residence;

9. Learning how to make choices and ordering from a fast food restaurant;

10. Learning how to observe basic personal safety skills;

11. Doing non-paid work in the community alongside peers without disabilities to improve social skills and establish connections; and

12. Receiving, as appropriate with their family, information and counseling on benefits planning and assistance in the process.

Transportation

Transportation services (including wheelchair) are a separate, billable component of day habilitation. Transportation may be provided to and/or from the beneficiary's residence or a location agreed upon by the beneficiary or authorized representative.

Place of Service

Day habilitation services are provided in a non-residential community setting, separate from the home in which the beneficiary resides.

Standards

Providers must possess a current, valid HCBS providers' license to provide adult day care (ADHC) services and enroll as a Medicaid waiver provider.

Service Limitations

The service unit is 15 minutes and is reimbursed at a flat rate. (See Appendix E for service procedure code/rate information).

Day habilitation services may be provided one or more hours per day, not to exceed eight hours per day or 2,080 hours per beneficiary per POC year.

The provider may only bill for transportation for the date(s) which the beneficiary received day habilitation services as indicated in the approved POC.

Both the beneficiary and the DSW must be present in order for the provider to bill for this service.

Services cannot be provided or billed for during the same hours on the same day as:

1. Supported Employment models;

2. Employment-Related Training;

3. Professional Services;

4. Individual and Family Support – Day/Night/Shared;

5. Community Integration and Development; or

6. Center-Based Respite.

Reimbursement Requirements

The use of the EVV system is mandatory for day habilitation services. The EVV system requires the electronic check in/out in the LaSRS® or another EVV system approved by BHSF and OCDD. Day habilitation transportation is exempt from this mandatory requirement.

Supported Employment

Supported employment is competitive work, for individuals who are eligible and assessed to need the service. The service is delivered in an integrated work setting, or employment in an integrated work setting in which the individuals are working toward competitive work that is consistent with the strengths, resources, priorities, interests, and informed choice of individuals for whom competitive employment has not traditionally occurred.

These services are provided to individuals who are **not** served by Louisiana Rehabilitation Services, need more intense, long-term follow along and usually cannot be competitively employed because supports cannot be successfully phased out.

Supported employment consists of intensive, ongoing supports that enable beneficiaries, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities need supports to perform in a regular work setting.

Supported employment includes activities needed to sustain paid work by beneficiaries, including supervision and training, as specified in the beneficiary's POC. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community–based employment for which an individual is compensated at or above minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Supported employment services also includes:

1. Assistance and prompting with personal hygiene;

2. Dressing;

3. Grooming;

4. Eating;

5. Toileting;

6. Ambulation or transfers;

7. Other personal care and behavioral support needs; and

8. Any medical task which can be delegated.

Personal care assistance may not comprise the entirety of this service. Interactions with beneficiaries are expected to be respectful and protect the individual's right of privacy for personal care issues as well as interactions involving any aspect of the individual's care and support.

Types of Supported Employment Services

Reimbursement for supported employment includes an individualized service plan for each of the following models.

Individual Placement or One-to-One Model

A one-to-one model is a placement strategy in which an employment specialist (job coach) places a beneficiary into competitive employment, provides training and support, and then gradually reduces time and assistance at the work site once a certain percentage of the job is mastered by the beneficiary. The beneficiary may then be transitioned to the Follow Along model of Supported Employment.

A beneficiary can move from the Follow Along model back to the One-to-One intensive model if the job changes or a new job has been secured for the beneficiary and new tasks have to be learned.

Follow Along

Follow Along services are designed for persons only requiring minimum oversight to maintain the beneficiary at the job site. Ongoing support services can be provided from more than one source.

Mobile Work Crew/Enclave

Mobile work crew/enclave is an employment setting in which a group of two or more beneficiaries,

but no more than eight perform work in a variety of locations under the supervision of a permanent employment specialist (job coach/supervisor). The beneficiaries may be dispersed throughout the company and among workers, or congregated as a group in one part of the business.

Supported employment group must be provided in a manner that promotes integration into the workplace and interaction between beneficiaries and people without disabilities in those workplaces.

Transportation

Transportation is an allowable activity within individual supported employment, but whenever possible, family, neighbors, friends, co-workers or community resources that can provide needed transportation without charge should be utilized.

Transportation is a separate, billable component of this service by the provider, but it must be billed on the same day as the group employment service is delivered.

Participants receiving supported employment, group services may also receive other services including prevocational or day habilitation services, but these services cannot be provided in the same day.

Place of Service

Supported employment is conducted in a variety of settings, in particular at work sites in which persons without disabilities are employed.

Standards

The provider must possess a valid certificate of compliance as a Community Rehabilitation Provider (CRP) from Louisiana Rehabilitation Services or have a current valid HCBS providers' license to provide supported employment services and 15 hours of documented initial and annual vocational-based training.

Transportation providers must possess a current valid HCBS providers' license to provide supported employment services and enroll as a Medicaid waiver provider.

Service Exclusions

Supported employment services cannot be provided or billed for during the same hours on the same day as:

1. Day habilitation;

2. Prevocational services;

3. Professional services;

4. Individualized and family support – day/night/shared; or

5. Center-based respite.

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

Services are not available to individuals who are eligible to participate in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Individuals with Disabilities Education Act [20 U.S.C. 1401 (26) and (29)].

Reimbursement Requirements

The use of the EVV system is mandatory for all supported employment services except supported employment transportation. The EVV system requires the electronic check in/out in LaSRS® or another EVV system approved by BHSF and OCDD.

Service Limitations

Supported Employment Model	Annual Limits	Weekly Limit	Daily Limit
One-to-One	1,280 ¼ hour units/year	5 days/week	8 hours/day
Follow Along	24 days per plan of care year		
Mobile Crew/Enclave	8,320 ¼ hour units per plan of care year without additional documentation	5 days/week	8 hours/day

Reimbursement

Supported Employment Model	Service Unit
One-to-One	15 minutes
Follow Along	1 unit per day
Mobile Work Crew/Enclave	15 minutes

NOTE: See Appendix E for service procedure code/rate information.

The provider may only bill for transportation for the date(s) which the beneficiary received supported employment services as indicated in the approved POC.

Prevocational Services

Prevocational services are intended to prepare a beneficiary for paid employment or volunteer opportunities in the community to the beneficiary's highest level. Prevocational services allow the individual to develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings.

Prevocational services are intended to develop and teach general skills such as:

1. Ability to communicate effectively with supervisors, co-workers, and customers;
2. Accepted community workplace conduct and dress;
3. Ability to follow directions and attend to tasks;
4. Workplace problem solving skills and general workplace safety;
5. Mobility training;
6. Observation of an employee of an area business to obtain information to make an informed choice regarding vocational interest;
7. Instruction on how to use work-related equipment;
8. Assistance in planning appropriate meals for lunch while at work;
9. Instruction on basic personal finance skills; and

10. Information and counseling to a beneficiary and, as appropriate, their family on benefits planning and assistance in the process.

Prevocational services are provided in a variety of locations in the community and are not limited to a fixed-site facility. Beneficiaries receiving prevocational services must have an employment related goal as part of their POC and service plan. The general habilitation activities must support their employment goals. Prevocational services are designed to create a path to integrated community based employment for which an individual is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Assistance with personal care may be a component of prevocational services, but may not comprise the entirety of the service.

The beneficiary may be paid for engaging in this service, according to federal regulations, by the prevocational services provider. If a beneficiary is paid above 50 percent of the minimum wage, there must be a review every six months to determine the suitability of this service rather than supported employment services.

Transportation

The provider is responsible for all transportation between prevocational sites.

Transportation services (including wheelchair) are a separate, billable as a component of prevocational services. Transportation may be provided to and/or from the participant's residence or a location agreed upon by the participant or authorized representative.

Standards

Providers must possess a current, valid HCBS Providers license to provide ADHC services and enroll as a Medicaid waiver provider.

Service Exclusions

Services are not available to beneficiaries who are eligible to participate in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Individuals with Disabilities Education Act [20 U.S.C. 1401(26) and (29)].

Service Limitations

Services must not exceed eight hours a day, five days per week, and cannot exceed 8,320 ¼ hour units of service per POC.

Prevocational services cannot be provided or billed for during the same hours on the same day as:

1. Day habilitation;
2. Supported employment models;
3. Professional services;
4. Individualized and family support – day/night/shared; or
5. Center-based respite.

Reimbursement

The service unit is 15 minutes. (See Appendix E for service procedure code/rate information).

Billing for this service is only allowed when the beneficiary and a DSW were both present.

The use of the EVV system is mandatory for all employment-related training services. The EVV system requires the electronic check in/out in the LaSRS® or another EVV system approved by BHSF and OCDD.

Environmental Accessibility Adaptations (EAA)

Environmental accessibility adaptations (EAAs) are physical modifications to the private residence or vehicle of the beneficiary or their family that are necessary to ensure the health, welfare, and safety of the beneficiary or that enable the beneficiary to function with greater independence in the home and/or community, and without these services, the beneficiary would require additional supports or institutionalization.

EAAs may include, but are not limited to, the following:

1. Installation of non-portable ramps and grab-bars;
2. Widening of doors;
3. Modification of bathroom facilities;
4. Installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies for the welfare of the beneficiary; and

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

Modifications may be applied to rental or leased property with the written approval of the landlord and approval of the LGE prior to the modifications being made.

Standards

Providers must be enrolled as a Medicaid waiver service provider and comply with applicable state and local laws governing licensure and/or certification.

All EAA providers must be registered with the Louisiana State Licensing Board for Contractors as a home improvement contractor, with the exception of providers of vehicle adaptations.

When required by state law, the person performing the service, such as building contractors, plumbers, electricians, or engineers, must meet applicable requirements for professional licensure and modifications to the home shall meet all applicable building code standards.

Providers of EAAs to vehicles must be licensed by the Louisiana Motor Vehicle Commission as a specialty vehicle dealer and accredited by the National Mobility Equipment Dealers Association under the Structural Vehicle Modifier category.

Service Exclusions

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

1. Flooring (carpet, wood, vinyl, tile, stone, etc.);

2. Interior/exterior walling not directly affected by a modification;

3. Lighting or light fixtures, which are for non-medical use;

4. Furniture;

5. Roofing, installation or repairs, this also includes covered ramps, walkways, parking areas, etc.;

6. Air conditioning or heating (solar, electric, or gas; central, floor, wall, or window units, heat pump-type devices, furnaces, etc.);

7. Exterior fences or repairs made to any such structures;

8. Motion detector or alarm systems for fire, security, etc.;

9. Fire sprinklers, extinguishers, hoses, etc.;

10. Pools;

11. Smoke 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 a modification, 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, whole home electrical generators, etc.);

15. Adaptations, which add to the total square footage or add total living area under the roof of the residence;
16. Repairs to the home or adaptations to the vehicle provided under the NOW; or

17. Repairs or modifications provided to previously installed home or vehicle modifications not provided under the NOW.

Home modification funds are not intended to cover basic construction cost. For example, in a new home a bathroom is already part of the building cost. Waiver funds can be used to cover the difference between constructing a bathroom and building an accessible or modified bathroom.

Modifications to the home shall meet all applicable state and local building or housing code standards.

Car seats are not considered as a vehicle adaptation.

Also excluded are any items covered under the Medicaid State Plan.

Service Limitations

There is a cap of $12,000 per beneficiary for EAAS for a three-year period.

Authorization to Exceed Cap

On a case-by-case basis, with supporting documentation and based on need, a beneficiary may exceed the cap with prior approval from the OCDD Central Office. Supporting documentation may include the following:

1. Three competitive bids;
2. Reason why additional bids were not obtained;
3. Other funding resources contacted for assistance;
4. Amount of increased supports needed due to not receiving the additional funding for the EAA;
5. Amount of decreased supports needed due to receiving the additional funding for the EAA; or
6. Inability of the beneficiary to personally fund the item.

The submitting LGE must describe the impact on the health and safety of the individual if the additional funding is not approved including the outcome if required to wait until budget allows for additional expenditures.

The support coordinator will assist the beneficiary in completing the necessary forms to request this approval.

Reimbursement

Items reimbursed through NOW funds shall be supplemental to any adaptations furnished under the Medicaid State Plan.

A written, itemized, detailed bid, including drawings with the dimensions of the existing and proposed floor plans relating to the modification, must be obtained and submitted to the LGE for prior authorization. The support coordinator will assist the beneficiary in completing the "Environmental Accessibility Adaptation Job Completion Form" (see Appendix D for a copy of this form) and any other associated documentation to request prior authorization. The LGE must approve the request prior to any work being initiated.

The EAA must be accepted by the beneficiary, fully delivered, installed, and operational, in the current POC year in which it was approved. It must be billed for reimbursement within the timely filing guidelines established for Medicaid reimbursement. Payment will not be authorized until

written documentation which demonstrates that the job is completed to the satisfaction of the beneficiary has been received by the support coordinator. If the adaptation is not accepted by the beneficiary, then OCDD Central Office will request the LGE contact the beneficiary to mediate the issue to a final resolution.

Upon completion of the work and prior to payment, the provider shall give the beneficiary a certificate of warranty for all labor and installation, and all warranty certificates from the manufacturers. The warranty for labor and installation must cover a period of at least six months.

The support coordinators must contact the LGE before approving modifications for a beneficiary leaving an ICF/IID).

Incontinence Supplies

Incontinence supplies including disposable diapers/ briefs, underwear/pull-on, bladder control pads, reusable and disposable under pads, liners, shield guards, disposable and reusable protective underwear, disposable penile wrap and other medically necessary incontinence products for individuals adults age 21 and older not cover under Medicaid State Plan:

1. Does not cover items that have been denied through DME and other programs for lack of medical necessity; and

2. To receive incontinence supplies, the beneficiary must have the following:

    a. Documentation of medical necessity or current 90L;

    b. Request for Incontinence Supplies form signed by physicians, PA or NP;

    c. Prescription from a physician, PA or NP; and

    d. Prior authorization (PA).

Service Limitations

Annual maximum cost is $2500/POC year without exception.

Specialized Medical Equipment and Supplies

Specialized medical equipment and supplies (SMES) are specified devices, controls, or appliances, which enable beneficiaries to increase their ability to perform the activities of daily living, ensure safety, or perceive, control, and communicate with the environment in which they live.

SMES include medically necessary durable and nondurable medical equipment not covered under the Medicaid state plan. The NOW program will not cover items that are not considered medically necessary. SMES may include the following:

1. Sip and puffer switches;

2. Specialized switches;

3. Voice activated, light activated, or motion activated devices to access the beneficiary's environment;

4. Portable electrical generators for beneficiaries whose medical condition warrants such an item, such as beneficiaries who require ventilators;

5. Items medically necessary for life support; and

6. Ancillary supplies and equipment necessary for the proper functioning of medically necessary items.

SMES may also be used for routine maintenance or repair of specialized equipment. All items shall meet applicable standards of manufacture, design, and installation. Pictures, brochures, and or other descriptive information must accompany the "Specialized Medical Equipment and Supplies Purchase and Repair Form" and must be approved by the LGE. Prior authorization must be received prior to purchase/maintenance/repair. (See Appendix D for a copy of this form).

Standards

The provider must also be enrolled as a Medicaid waiver provider.

All agencies who are vendors of technological equipment and supplies must be enrolled in the Medicaid program as an assistive devices provider and must meet all applicable vendor standards and requirements for manufacturing, design and installation of technological equipment and supplies.

Service Exclusions

Excluded are those equipment and supplies that are of general utility or maintenance and are not of direct medical or remedial benefit to the beneficiary, such as:

1. Appliances (washer, dryer, stove, dishwasher, vacuum cleaner, whole-home electrical generators, etc.);

2. Daily hygiene products (deodorant, lotions, soap, toothbrush, toothpaste, feminine products, Band-Aids, Q-tips, etc.);

3. Rent subsidy;

4. Food, bed covers, pillows, sheets etc.;

5. Swimming pools, hot tubs etc.;

6. Eye exams;

7. Athletic and tennis shoes;

8. Automobiles;

9. Van lifts for vehicles that do not belong to the beneficiary or their family;

10. Adaptive toys or recreation equipment (swing set, etc.);

11. Personal computers and software;

12. Exercise equipment;

13. Taxi fares, intra and interstate transportation services, and bus passes;

14. Pagers, including monthly service;

15. Telephones, including mobile telephones and monthly service; and

16. Home security systems, including monthly service.

Excluded are those durable and non-durable items that are available under the Medicaid State Plan. Support coordinators shall pursue and document all alternate funding sources that are available to the beneficiary before submitting a request for approval to purchase or lease specialized medical equipment and supplies. To avoid delays in service provisions/implementation, the support coordinator should be familiar with the process for obtaining SMES or durable medical equipment (DME) through the Medicaid State Plan.

Technology Supports with Remote Features

Mobile Emergency Response System is an on-the-go mobile medical alert system, used in and outside the home. This system has cellular/global positioning system (GPS) technology, two-way speakers and no base station required.

Medication Reminder System is an electronic device programmed to remind individual to take medications by a ring, automated recording or other alarm. The electronic device may dispense controlled dosages of mediation and may include a message back to the center if a medication has not been removed from the dispenser. Medications must be set up by a registered nurse (RN).

Other equipment used to support someone remotely may include but not limited to:

1. Electronic motion door sensor devices;
2. Door alarms;
3. Web-cams;
4. Telephones with modifications (large buttons, flashing lights);
5. Devices affixed to wheelchair or walker to send alert when fall occurs;
6. Text-to-speech software;
7. Intercom systems;
8. Tablets with features to promote communication; or
9. Smart device speakers.

Remote Technology Service Delivery covers monthly response center/remote support monitoring fee and tech upkeep (no internet cost coverage).

Remote Technology Consultation is the evaluation of tech support needs for an individual, including the functional evaluation of technology available to address the assess needs and support the individual to achieve outcomes identified in the POC.

Service Limitations

There is a cap of $5,000 per beneficiary for specialized medical equipment and supplies for a three-year period.

Authorization to Exceed Cap

On a case-by-case basis, with supporting documentation and based on need, a beneficiary may be able to exceed this cap with prior approval from the OCDD Central Office. The support coordinator will assist the beneficiary in completing the necessary forms to request approval.

Supporting documentation may include the following:

1. Three competitive bids;
2. Reason why additional bids were not obtained;
3. Other funding resources contacted for assistance;
4. Amount of increased supports needed due to not receiving the additional funding for the SMES;
5. Amount of decreased supports needed due to receiving the additional funding for the SMES; or
6. Inability of the beneficiary to personally fund the item.

The submitting LGE must describe the impact on the health and safety of the individual if the additional funding is not approved including the outcome if required to wait until budget allows for additional expenditures.

Personal Emergency Response Systems

A Personal Emergency Response System (PERS) is a rented electronic device that enables beneficiaries to secure help in an emergency. PERS services are available to beneficiaries who meet the following criteria:

1. Have a demonstrated need for quick emergency back-up;
2. Unable to use other communication systems as the systems are not adequate to summon emergency assistance; or

3. Do not have 24-hour direct supervision (such as IFS or other paid supports).

The beneficiary may wear a portable "help" button to allow for mobility. The PERS is connected to the person's phone and programmed to signal a response center to secure help in an emergency once the "help" button is activated. The response center is staffed by trained professionals.

PERS services include the cost of maintenance and training the beneficiary to use the equipment.

Mobile Emergency Response System is an on-the go mobile medical alert system, used in and outside the home. This system will have cellular/GPS technology, two-way speakers and no base station will be required.

Standards

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

Service Limitations

Coverage of the PERS is limited to the rental of the electronic device.

Reimbursement

Reimbursement will be made for a one-time installation fee for the PERS unit. A monthly fee will be paid for the maintenance of the PERS. (See Appendix E for service procedure code/rate information).

Professional Services

Professional services are designed to increase the beneficiary's independence, participation and productivity in the home, work and community. Beneficiaries, up to the age of 21, who participate in the NOW program must access these services through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

Professional services may only be furnished and reimbursed through NOW when the services are not covered under the Medicaid State Plan, including services available through the individual's Medicaid managed care organization.

Professional services may be utilized for the following:

1. Performing assessments and/or re-assessments and recommendations;

2. Providing consultative services and recommendations;

3. Providing training or therapy to an individual and/or their natural and formal supports necessary to either develop critical skills that may be self-managed by the beneficiary or maintained according to the beneficiary's needs;

4. Intervening in and stabilizing a crisis situation, behavioral or medical that could result in the loss of home and community-based services; or

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

Professional services include psychological, social work, and nutritional services that assist the beneficiary, and unpaid/paid caregivers in carrying out the approved POC and which are necessary to improve the beneficiary's independence and inclusion in their community. Service intensity, frequency, and duration will be determined by individual need.

Psychological Services

Psychological services are direct services performed by a licensed psychologist (Ph.D.), as specified by State law and licensure. These services are for the treatment of behavioral or mental conditions that address personal outcomes and goals desired by the beneficiary and his or her support team. Services must be reasonable and necessary to preserve, improve, or maintain adaptive behaviors or to decrease maladaptive behaviors of the beneficiary.

Psychological services include the following:

1. Counseling (a variety of techniques and procedures used by the therapist, e.g., structuring and reinforcement, social modeling, and functional activities);

2. Behavior evaluation for the purpose of therapy;

3. Intervening and stabilizing a crisis situation;

4. Ongoing therapeutic support;

5. Ongoing behavior training for staff and/or families;

6. Administering and interpreting tests and measurements within the scope of practice of behavior therapy;

7. Administering, evaluating, and modifying treatment and consulting within the scope of practice of behavior therapy;

8. Adapting environments specifically for the beneficiary; and

9. Consultative services and recommendations.

Social Work Service

Social work service is highly specialized direct counseling furnished by a licensed clinical social worker (LCSW), designed to meet the unique counseling needs of beneficiaries with developmental disabilities. Counseling may address areas such as human sexuality, depression, anxiety disorders, and social skills. Services must only address the beneficiary's personal outcomes and goals listed in their approved POC.

Nutritional/Dietary Service

Nutritional/dietary service is a medically necessary service that has been ordered by a physician to be provided by a licensed registered dietician or licensed nutritionist directly to the beneficiary. Service may address health care and nutritional needs related to prevention and primary care activities, treatment and diet.

Nutritional/dietary service may include planning food and nutrition programs to help prevent and treat illnesses by promoting healthy eating habits through education, evaluating the beneficiary's diet, and as necessary suggesting modifications to the beneficiary's diet.

Reimbursement will be available for the service provided directly to the beneficiary by a dietician or nutritionist and not for the supervision of a dietician or nutritionist who is performing the hands-on service.

Standards

Professionals rendering service(s) must possess a current valid Louisiana license to practice with one-year post licensure experience in their field of expertise. The professional may be employed by or contracted with the HCBS Provider (Personal Care Attendant) module, or SIL module) agency, or home health agency to provide this service.

Providers must be licensed by the Louisiana Department of Health (LDH) and enrolled as a waiver service provider of PCA, SIL, or home health services.

Agencies enrolled as both SIL and PCA provider types shall bill these professional services under their PCA number in accordance with the requirements of the fiscal intermediary. Agencies enrolled as only SIL or home health providers shall bill under their SIL or home health provider number.

Service Exclusions

The following activities are not reimbursable:

1. Friendly visiting;
2. Attending meetings;
3. Time spent on paperwork or travel;
4. Time spent writing reports and progress notes;
5. Time spent on billing of services; and
6. Other non-Medicaid reimbursable activities such as time spent on general staff training not related to training for the natural or paid support regarding the beneficiary's POC.

Additionally, services available through the State Medicaid Plan must be exhausted prior to accessing professional services.

Service Limitations

There is a $2,250 cap per beneficiary per POC year for the combined range of professional services in the same day but not at the same time.

A beneficiary may receive two or more professional services on the same day; however, these two or more professional services will not be authorized at the same time.

Professional services are limited to psychological, social work, and nutritional/dietary services.

Professional services cannot be provided or billed for during the same hours on the same day as:

1. Day habilitation,
2. Transportation for day habilitation,

3. Supported employment models,

4. Transportation for supported employment models,

5. Prevocational services,
6. Individual and family support – day/night/shared,

7. Skilled nursing services, or

8. Center-based respite.

In order to bill for this service, the beneficiary must be present when the professional rendered the service.

Reimbursement

The service unit is 15 minutes.

Skilled Nursing

Skilled nursing is medically necessary nursing services ordered by a physician and provided by a registered nurse or a licensed practical nurse licensed to practice in the state of Louisiana. Skilled nursing must be provided by a licensed, enrolled home health agency and requires an individual nursing service plan, and must be included in the beneficiary's approved POC.

Skilled nursing is designed to meet the needs of the beneficiary, to prevent institutionalization, and teach the beneficiary and/or family necessary medical or related interventions, such as medication management, as ordered by a physician.

Nursing consultations are offered on an individual basis only. Nurse consultations are available to beneficiaries who require short term nursing consultations for family training, skill development etc., as specified in the beneficiary's approved POC.

All Medicaid State Plan services must be utilized before accessing this service. Beneficiaries under the age of 21 must access skilled nursing services as outlined on the POC through the EPSDT Program.

Shared Supports

Skilled nursing may be shared when there is more than one beneficiary in the home receiving these services. Payment for shared services must be coordinated with the service authorization system and specified in each beneficiary's approved POC.

Standards

The provider must possess a current valid license as a home health agency by the LDH and be enrolled as a Medicaid waiver provider of home health.

Service Exclusions

Skilled nursing will not be reimbursed when the beneficiary is in a hospital or other institutional setting.

Service Limitations

Skilled nursing cannot be provided or billed for during the same hours on the same day as:

1. Transportation for day habilitation;
2. Transportation for supported employment;
3. Professional services;
4. Individualized and family support – day/night/shared; or
5. Center-based respite.

Both the beneficiary and the nurse must be present in order for the provider to bill for this service.

Authorization to Exceed 12-Hour Skilled Nursing Service Cap

Requests for 12 hours or less per day of skilled nursing may be approved by the LGE. All requests received for more than 12 hours per day must be approved by the LDH Medical Director and Medical Evaluation Team and will be forwarded to the LGE by the OCDD Central Office for processing. A request to increase the number of hours per day above the number of hours already approved requires the primary care physician to document the medical change(s) of the beneficiary necessitating the increase in the request for nursing services.

Reimbursement

The service unit is 15 minutes.

One – Time Transitional Expenses

One – time transitional expenses are non-reoccurring set-up expenses for beneficiaries, aged 18 years or older, who are transitioning from an ICF/IID or other institution, to their own home or apartment in the community of their choice. Beneficiaries have the right to choose the furnishings for their home or apartment purchased with these funds.

The beneficiary's home is defined as the beneficiary's own residence and does not include the residence of any family member or a substitute family care home.

Allowable transitional expenses include the following:

1. Purchase of essential furnishings such as:

    a. Bedroom and living room furniture;

    b. Table and chairs;

    c. Window blinds;

    d. Eating utensils;

    e. Food preparation items; and

    f. Bed/bath linens.

    NOTE: Purchased items belong to the beneficiary and may not be misused or sold under any circumstances.

2. Moving expenses required to occupy and use a community domicile;

3. Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy; and

4. Nonrefundable security deposits and set-up fees (i.e. telephone, utility, heating by gas) which are required to obtain a lease on an apartment or home.

Standards

This service shall only be provided by the LDH OCDD state office with coordination of appropriate entities.

Service Exclusions

The following expenses are not covered under one-time transitional services:

1. Payments for housing or rent;
2. Payments for regular utility charges;
3. Household appliances/items that are intended for purely recreational purposes;
4. Refundable security deposits;
5. Food purchases; and
6. Payment of furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

Service Limitations

One-time transitional expenses have a life time limit of $3,000 per beneficiary. Service authorization and transitional expenses are time limited.

Adult Companion Care

Adult companion care services assist the beneficiary to achieve and/or maintain the outcomes of increased independence, productivity and inclusion in the community. These services are designed for an individual who lives independently and can manage their own household with limited supports. The companion is a principal care provider chosen by the beneficiary, who provides services in the beneficiary's home and lives with the beneficiary as a roommate. Adult companion care services are furnished through a licensed provider organization as outlined in the beneficiary's POC. This service includes the following:

1. Providing assistance with all of the activities of daily living as indicated in the beneficiary's POC;
2. Providing community integration and coordination of transportation services, including medical appointments; and
3. Providing medical and physical health care that can be delivered by unlicensed persons in accordance with Louisiana's Nurse Practice Act.

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

1. The companion shall be available in accordance with a pre-arranged time schedule and available by telephone for crisis support on short notice; and

2. The companion is responsible for participating in, and abiding by, the POC; maintaining records in accordance with state and provider requirements; and purchasing their own food and personal care items.

Service Limits

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

Service Exclusions

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

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

1. Supported independent living;
2. Individual and Family support;
3. Substitute family care; or
4. Skilled nursing.

Standards

Provider Qualifications

Providers must be licensed by the LDH as a HCBS provider and must meet the module specific requirements for the service being provided.

Housing Stabilization Transition Service and Housing Stabilization Service

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

Housing Stabilization Transition Service

Housing stabilization transition enables beneficiaries who are **transitioning into a PSH unit**, including those transitioning from institutions, to secure their own housing. The service is provided while the beneficiary is in an institution and preparing to exit the institution using the waiver. The 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:

    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:

    a. Arranging or providing transportation;

    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:

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 development of the POC and incorporating elements of the housing support plan; and

5. Exploring alternatives to housing if permanent supportive housing is unavailable to support completion of the transition.

Housing Stabilization Service

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. 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:

   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. Participating in the development of the POC, incorporating elements of the housing support plan;

3. Developing an individualized housing stabilization service provider plan based upon the housing assessment that:

   a. Includes short and long-term measurable goals for each issue;

   b. Establishing the beneficiary's approach to meeting the goal(s); and

   c. Identifying where other provider(s) or services may be required to meet the goal(s).

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

5. Providing ongoing communication with the landlord or property manager regarding:

   a. Beneficiary's disability;

   b. Accommodations needed; and

   c. Components of emergency procedures involving the landlord or property manager.

6. Updating the housing support plan annually or as needed due to changes in the beneficiary's situation or status; and
7. Providing supports to retain housing or locate and secure housing if at any time the beneficiary's housing is placed at risk (e.g., eviction, loss of roommate or income).

Standards

Housing stabilization transition services or 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 Freedom of Choice form.

Service Exclusions

Housing stabilization transition services or housing stabilization 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

No more than 165 units of combined housing stabilization transition services and housing stabilization services can be used per POC without written approval from the OCDD state office.

Reimbursement

Housing stabilization transition service and housing stabilization service are reimbursed at a prospective flat rate for each approved unit of service provided to the beneficiary.

Payment will not be authorized until the final POC approval is received.

The LGE 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 beneficiary 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.

Monitored In-Home Caregiving Services

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

The goal of this service is to provide a community based option that provides continuous care, supports, and professional oversight and is achieved by promoting a cooperative relationship between a beneficiary, a principal caregiver, the professional staff of a monitored in-home caregiver agency provider, and the beneficiary's support coordinator.

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

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

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

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

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

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

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

Service Exclusions and Restrictions

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

a. Individual family support;

b. Center-based respite;

c. Supported independent living;

d. Adult companion care; or

e. Skilled nursing care.

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

The agency provider must:

a. Assess and approve the home in which services will be provided, and enter into contractual agreements with caregivers whom that agency has approved and trained.

b. Capture daily notes electronically and use the information collected to monitor beneficiary health and caregiver performance.

c. Take such notes available to support coordinators and the state, upon request.

d. Secure, web-based information collection from principal caregivers for the purposes of monitoring beneficiary health and caregiver performance. All protected health information must be transferred, stored, and otherwise utilized in compliance

with applicable federal and state privacy laws.

e. Sign, maintain on file, and comply with the LDH Health Insurance Portability and Accountability Act (HIPAA) business associate addendum.

The agency provider will pay per diem stipends to caregivers. The per diem for monitored in-home caregiving services does not include payments for room and board. The Department shall reimburse for monitored in-home caregiving services based on a two-tiered model which is designed to address the beneficiary's acuity. Reimbursement will not be made for room and board of the principal caregiver, and federal financial participation is not available for room and board.

Service Limitations

LDH will reimburse for MIHC based on a two tiered model which is designed to address the beneficiary's acuity. The following service limits apply:

1. 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 activities of daily living (ADL) or (instrumental activities of daily living (IADL) assistance; and

2. Provision of MIHC services outside of the borders of the state (e.g., overnight excursions, vacations, etc.) is prohibited without prior written approval by OCDD of its designee.

Provider Qualifications

MIHC providers must:

1. Be licensed according to the home and community based service provider licensing requirements contained in the La. R.S. 40:2120.2-2121.9 and their implementing regulations;

2. Enroll as a Medicaid MIHC provider; and

3. Comply with LDH rules and regulations.

The principal caregiver must:

1. Be at least 18 years of age;

2. Live in the home with the beneficiary; and

3. Be available 24 hours a day, 7 days a week.

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

Expanded Dental Services for Adult Waiver Beneficiaries

Please refer to the Dental Benefit Program Manager Manual:

https://ldh.la.gov/assets/medicaid/DBPMP/DBPM_Manual_2022-04-01.pdf

Financial Management Services

Financial management services (FMS) are provided by a Medicaid enrolled fiscal employer agent (F/EA). The F/EA) is the fiscal agent that assures financial accountability for self-direction services.

FMS assist a beneficiary or an authorized representative that has been identified as able to self-direct their waiver services live independently in the community promote personal choice and control over the delivery of waiver and State Plan services, including who provides the services and how services are provided. FMS must be included and prior authorized in the approved POC prior to participation in self-direction.

Refer to the Chapter 3: Fiscal/Employer Agent (F/EA) Manual for additional information at: https://www.lamedicaid.com/provweb1/providermanuals/manuals/FEA/FEA.pdf