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 recipient, and members of the recipient's support network, which may include family members, service providers, appropriate professionals, and other individuals who know the recipient best. The plan should contain all paid and unpaid services that are necessary to support the recipient in his/her home and promote greater independence.

Recipients must receive at least one NOW service every 30 days.

Individual and Family Support

Individual and Family Support (IFS) services are defined as direct support and assistance provided to a recipient in his/her home or in the community that allow the recipient to achieve and/or maintain increased independence, productivity, enhanced family functioning, and inclusion in the community or for the relief of the primary caregiver. IFS services may not supplant primary care available to the recipient through natural and community supports.

IFS services include the following allowable activities:

- 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.

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

    - Housekeeping,
    - Laundry,
    - Cooking,
    - Evacuating the home in emergency situations,
    - Shopping, and
    - Money management, which includes bill paying.

- Assistance in participating in community, health, and leisure activities which may include accompanying the recipient to these activities.

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

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

- Accompanying the recipient 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 must develop an Individualized Service Plan for the provision of IFS services that documents the supports to be provided to the recipient that allows him/her to meet the goals identified on the approved Plan of Care.

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 recipient. Waking hours are the period of time when the recipient is awake and not limited to traditional daytime hours. The IFS worker must be awake, alert, and available to respond to the recipient'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 Plan of Care.

Individual and Family Support - Night

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

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

The IFS – N worker must be immediately available and in the same residence as the recipient to be able to respond to the recipient'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 Plan of Care with supporting documentation in the provider's service plan. Supporting documentation shall outline the recipient's safety, communication, and response methodology planned for and agreed to by the recipient and/or his/her authorized representative.

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

- Recipients who are able to notify direct support workers of their need for assistance during sleeping hours.

- The support team assesses the recipient's ability to awaken staff. If it is determined that the recipient is able to awaken staff, then the approved Plan of Care shall reflect the recipient's request that the IFS – N worker be allowed to sleep.

- The support team should consider the use of technological devices that would enable the recipient 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 recipient 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.

- A review shall include review of log notes indicating instances when IFS – N staff was awakened to attend to the recipient and an acknowledgement by the recipient that the IFS – N staff responded to his/her 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.

- 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 Plan of Care.

Shared Supports

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

- Have a common IFS provider agency,

- Agree to share services, and

- Assurance is made for each recipient's health and safety.

Service can be in the home of a recipient or in the community. The direct service worker must be present with the recipients, but does not have to be in the same room with all the recipients 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 recipients in their choice of activities.

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

The decision to share staff must be reflected on the recipients' Plan of Care and based on an individual-by-individual determination with reimbursement rates adjusted accordingly.

Sharing Supports among Roommates

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

Plans of Care for recipients sharing supports among roommates must be submitted at the same time to the Office for Citizens with Development Disabilities (OCDD) regional waiver office to allow for concurrent review. Requests sent to the OCDD regional waiver office must include:

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

- A Plan of Care for each recipient 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 recipients, and

- Copies of budget sheets and typical weekly schedules of all recipients who will be sharing supports.

  NOTE: Budget sheets and Plans of Care must be consistent between the recipients when supports are shared.

Sharing Supports among Non-Roommates

Recipients who choose to share supports casually are **not** required to sign a release of information form or list the names of the other recipients on the Plan of Care.

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

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 recipient, his/her family member or others a separate fee for transportation.

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

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

Place of Service

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

- A worker's residence, unless the worker's residence regardless of the relationship, is a certified foster care home.
- A hospital once the recipient has been admitted.
- A licensed congregate setting. A licensed congregate setting includes licensed ICFs/DD, community homes, Center-Based Respite facilities, and Day Habilitation programs.
- 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 OCDD regional waiver office and included in the recipient's Plan of Care.
- Outside the United States or territories of the United States.

Standards

Providers must possess a current, valid Home and Community-Based Service Providers License to provide personal care attendant services and enroll as a Medicaid provider for waiver services or be a direct service worker providing support under an authorized Self-Direction option.

Service Exclusions

Recipients who live in distinct residences may not share in-home supports when the recipients are in their own respective homes. This includes recipients 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: Day Habilitation, Supported Employment models, Employment-Related Training, Transportation for Habilitation Services, Professional Services, Center-Based Respite, Skilled Nursing Services, and Individualized and Family Support - Night/Shared.

The IFS – D or N worker may not work more than 16 hours in a 24-hour period unless there is a documented emergency or a time limited, non-routine need that is documented in the recipient's approved Plan of Care. Habitual patterns of a worker providing more than16 hours of paid services per day will be investigated.

IFS – D services may not exceed 16 hours in a 24 hour period, unless an exception is documented in the recipient's approved Plan of Care.

IFS – N services must be a minimum of 8 hours for recipients who receive 24 hours of care.

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

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

Authorization for Worker to Exceed 16-Hour Service Limitation

The OCDD regional waiver office may approve Individual and Family Support 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:

- On a non-routine, time limited basis when the primary caregiver is unable to provide care to the recipient 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. The definition of time limited is one exception per quarter for up to seven days. Any request beyond this limit would require approval from the OCDD Central Office.

- In emergency situations that could include hurricane, tornado, flooding, or other acts of God.

Requests must be made by the recipient to the support coordinator. Upon notification of the request, the support coordinator is responsible for submitting a revision request to the OCDD regional waiver office by the next business day. Requests must include supporting documentation.

Reimbursement

The service unit is 15 minutes and is reimbursed at a flat rate. (See Appendix E for Rate and Billing Code information)

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

Center-Based Respite

Center-Based Respite (CBR) service is temporary short-term care provided to a recipient who requires support and/or supervision in his/her day-to-day life due to the absence or relief of the primary caregiver.

The recipient's routine is maintained while receiving CBR service so that he/she is able to attend school, work, or other community activities and outings. Community outings shall be specified in the recipient's approved Plan of Care and shall include activities the recipient would receive if he/she were not in CBR care.

Transportation

The CBR provider is responsible for transporting the recipient 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 Home and Community-Based Service 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 recipient per Plan of Care year.

CBR services cannot be provided or billed for during the same hours on the same day as: Day Habilitation, Supported Employment models, Employment-Related Training, Transportation for Habilitation Services, Professional Services, Individual and Family Support–Day/Night/Shared, Skilled Nursing services, or Community Integration and Development.

Both the recipient and the direct service worker 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 Rate and Billing Code information)

Community Integration Development

Community Integration Development (CID) facilitates the development of opportunities to assist recipients in becoming involved in their community through the creation of natural supports. The purpose of this service is to encourage and foster the development of meaningful relationships in the community to reflect the recipient's choices and values (e.g., doing preliminary work toward membership in civic, neighborhood, church, and leisure groups).

Objectives outlined in the recipient’s Plan of Care will afford opportunities to increase community inclusion, participation in leisure/recreational activities, and encourage participation in volunteer and civic activities.

The provider must develop an Individualized Service Plan for the provision of CID, which must document the supports that will be provided to the recipient to meet his/her goals based on the recipient’s approved Plan of Care.

CID differs from Individual and Family Support (IFS) services in that CID is used for the development of community connections.

To utilize this service, the recipient may or may not be present as identified in the approved CID service plan.

Shared Supports

CID services may be performed by shared staff for up to three waiver recipients who have a common direct service provider agency. Based on a recipient's individual determination, the shared staff shall be reflected in each recipient's approved Plan of Care as a special billing code, and rates should be adjusted accordingly.

Recipients who agree to share supports must sign a release of information allowing each recipient's name to be used in the Plan of Care of the other recipients with whom services are shared.

Transportation

The cost of transportation is included in the rate paid to the provider. There is no mileage limit specified for this service.

Standards

The provider must possess a current, valid Home and Community-Based Service Providers License to provide supervised independent living or personal care attendant services and enroll as a Medicaid waiver provider.

Service Limitations

CID services, including any combination of shared and non-shared CID services, are limited to 60 hours per recipient per Plan of Care year.

To utilize this service, the recipient may or may not be present as identified in the approved Plan of Care.

Reimbursement

The service unit is 15 minutes and is reimbursed at a flat rate. (See Appendix E for Rate and Billing Code information)

Residential Habilitation – Supported Independent Living

Residential Habilitation – Supported Independent Living (SIL) services assist recipients, age 18 years of age 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.

SIL services also assist recipients in obtaining financial aid, housing, advocacy and self-advocacy training as appropriate, emergency support, trained staff, and accessing other programs for which he/she 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 recipient for community integration development.

Place of Service

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

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

SIL services cannot be provided in the following settings:

- A Substitute Family Care home or
- A Center-Based Respite facility.

Standards

Providers must possess a current, valid Home and Community-Based Service Providers License to provide supervised independent living services and enroll as a Medicaid waiver provider.

Service Exclusions

Legally responsible relatives may not be SIL providers. Payment for SIL does not include payments made directly or indirectly to the members of the recipient's immediate family.

SIL does not include the cost of the following:

- Meals or the supplies needed for meal preparation,
- Room and board,
- Home maintenance or upkeep and improvement,
- Routine care and supervision which could be expected to be provided by a family member, or
- 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 Plan of Care year, except when the recipient is in center based respite care. When a recipient 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 center.

Provider-owned or recipient leased property where services are provided must be compliant with the Americans with Disabilities Act as applicable to the recipient's individual needs.

Recipients 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 recipient, the provider shall not terminate or refuse to renew a recipient's lease based solely on the recipient's choice of utilizing another provider for his/her service delivery. A recipient's lease shall not be tied to a provider's service agreement.

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 his/her designee.

The SIL per diem rate will not be paid to an SIL provider agency for recipients in the Self-Direction option, as these recipients are responsible for directing their own care.

Reimbursement

The service unit is one per day per Plan of Care year and is reimbursed at a flat rate. (See Appendix E for Rate and Billing Code information)

Substitute Family Care

Substitute Family Care (SFC) is a stand-alone family living arrangement for recipients, age 18 years of age or older, in which the SFC house parents assume the direct responsibility for the recipient's physical, social, and emotional well-being and growth, including family ties.

SFC provides recipients who live in a licensed SFC home with the following:

- Day programming,
- Transportation,
- Independent living training,
- Community integration,
- Homemaker,
- Chore,
- Attendant care and companion services, and
- Medication oversight (to the extent permitted under state law).

The provider is required to develop an Individualized Service Plan (ISP) for the provision of Substitute Family Care services based on the recipient's approved Plan of Care.

Standards

Providers must possess a current, valid Home and Community-Based Service Providers License to provide substitute family care services 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 recipient's immediate family.

SFC homes shall not be Supported Independent Living settings.

Service Limitations

No more than three recipients, who are unrelated to the SFC provider, are allowed to live in an SFC setting.

SFC services cannot exceed 365 days a year.

Reimbursement

The service unit is one service per day and is reimbursed at a flat rate. (See Appendix E for Rate and Billing Code information)

Day Habilitation

Day Habilitation services provide recipients, age 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.

Day Habilitation services must be directed by a service plan that has been developed by the provider to address the recipient's Plan of Care goals, and to provide assistance and/or training in the performance of tasks related to acquiring, maintaining, or improving skills including but not limited to the following:

- Personal grooming,
- Housekeeping,
- Laundry,
- Cooking,
- Shopping, and
- Money management.

Day Habilitation services must be coordinated with any physical, occupational, or speech therapies, employment-related training or employment listed in the recipient's approved Plan of Care, and may serve to reinforce skills or lessons taught in school, therapy, or other settings to

attain or maintain the recipient's maximum functional level. The recipient 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:

- 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.
- Receiving personal care skills training at a facility to improve his/her adaptive skills.
- Participating in a community inclusion activity designed to enhance the recipient's social skills.
- Training in basic nutrition and cooking skills at a community center.
- Participating, for an older recipient, 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.
- Receiving aerobic aquatics in an inclusive setting to maintain the recipient's range of motion.
- Learning how to use a vacuum cleaner.
- Learning how to make choices and ordering from a fast food restaurant.
- Learning how to observe basic personal safety skills.
- Doing non-paid work in the community alongside peers without disabilities to improve social skills and establish connections.
- Receiving, as appropriate with his/her family, information and counseling on benefits planning and assistance in the process.

Transportation

Transportation provided for the recipient to the site of the day habilitation or between the day habilitation and supported employment model site (if the recipient receives services in more than one place) is reimbursable when day habilitation has been provided.

The NOW reimburses two separate per diem rates for transportation when Day Habilitation and/or Supported Employment services have been provided to the recipient. One rate covers regular transportation and the other rate covers wheelchair transportation.

Reimbursement may be made for a one-way trip if the reason is documented in the provider's transportation log. There is a maximum fee per day that may be charged for transportation, regardless of the number of trips made per day.

Place of Service

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

Standards

Providers must possess a current, valid Home and Community-Based Service Providers License to provide adult day care services and enroll as a Medicaid waiver provider. Transportation providers must carry at least $1,000,000 liability insurance on the vehicles used in transporting the recipients.

Service Limitations

The service unit is 15 minutes and is reimbursed at a flat rate. (See Appendix E for Rate and Billing Code 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 recipient per Plan of Care year.

The provider may only bill for transportation for the date(s) which the recipient received Day Habilitation services as indicated in the approved Plan of Care.

Both the recipient and the direct service worker 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: Supported Employment models; Employment-Related Training; Professional Services; Individual and Family Support – Day/Night/Shared; Community Integration and Development; or Center-Based Respite.

Supported Employment

Supported employment is competitive work, for individuals who are 18 years of age or older, 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 recipients, 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 recipients, including supervision and training, as specified in the recipient's Plan of Care.

Supported Employment services also includes assistance 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.

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 recipient 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 recipient. The recipient may then be transitioned to the Follow Along model of Supported Employment.

A recipient 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 recipient and new tasks have to be learned.

Follow Along

Follow Along services are designed for persons only requiring minimum oversight to maintain the recipient 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 recipients, but fewer than eight perform work in a variety of locations under the supervision of a permanent employment specialist (job coach/supervisor). The recipients may be dispersed throughout the company and among workers, or congregated as a group in one part of the business.

Transportation

Transportation provided for the recipient to the site of the supported employment model, or between the day habilitation and supported employment model site (if the recipient receives services in more than one place) is reimbursable when Supported Employment services have been provided.

The NOW reimburses two separate per diem rates for transportation when Day Habilitation and/or Supported Employment services have been provided to the recipient. One rate covers regular transportation and the other rate covers wheelchair transportation.

Reimbursement may be made for a one-way trip if the reason is documented in the provider's transportation log. There is a maximum fee per day that may be charged for transportation, regardless of the number of trips made per 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 15 hours of documented initial and annual vocational-based training.

Transportation providers must possess a current valid Home and Community-Based Service Providers License to provide adult day care services and enroll as a Medicaid waiver provider. The licensed provider must carry at least $1,000,000 liability insurance on the vehicles used in transporting the recipients.

Service Exclusions

Supported Employment services cannot be provided or billed for during the same hours on the same day as: Day Habilitation, Employment-Related Training, Professional Services, Individualized and Family Support – Day/Night/Shared, or 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 recipients 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 (16) and (71).

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

Billing for this service is only allowed when the recipient and direct service worker were both present.

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 Rate and Billing Code information.

The provider may only bill for transportation for the date(s) which the recipient received Supported Employment services as indicated in the approved Plan of Care.

Employment-Related Training

Employment-Related Training services consists of paid employment for recipients age 18 or older, for whom competitive employment at or above the minimum wage is unlikely, and who need intensive ongoing support to perform in a work setting because of their disability. Services include teaching such concepts as compliance, task completion, problem solving, and safety to address underlying generalized habilitation goals (e.g. attention span, motor skills) that are associated with performing compensated work.

Employment-Related Training services include, but are not limited to:

- Assistance and prompting in the development of employment-related skills. This may include assistance with the following:
    - Personal hygiene,
    - Dressing,
    - Grooming,
    - Eating,
    - Toileting,
    - Ambulation or transfers,
    - Behavioral support needs, and any medical task, which can be delegated.

      NOTE: Personal care assistance may not comprise the entirety of this service.
- Employment at a commensurate wage at a provider facility for a set or variable number of hours,
- Observation of an employee of an area business to obtain information to make an informed choice regarding vocational interest,
- Instruction on how to use work-related equipment,
- Instruction on how to observe basic work-related personal safety skills,
- Assistance in planning appropriate meals for lunch while at work,
- Instruction on basic personal finance skills, and

- Information and counseling to a recipient and, as appropriate, his/her family on benefits planning and assistance in the process.

The recipient may be paid for engaging in this service, according to federal regulations, by the Employment-Related Training provider. If a recipient 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 cost of transportation is included in the rate paid to the provider. There is no mileage limit specified for this service.

Standards

Providers must possess a current, valid Home and Community-Based Service Providers License to provide adult day care services and enroll as a Medicaid waiver provider. Providers must also have a valid certificate of compliance as a Community Rehabilitation Provider (CRP) from Louisiana Rehabilitation Services or have 15 hours of documented initial and annual vocational-based training.

Service Exclusions

Services are not available to recipients 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 (16) and (71).

Service Limitations

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

Employment-Related Training cannot be provided or billed for during the same hours on the same day as: Day Habilitation, Supported Employment models, Professional Services, Individualized and Family Support – Day/Night/Shared, or Center-Based Respite.

Reimbursement

The service unit is 15 minutes. (See Appendix E for Rate and Billing Code information)

Billing for this service is only allowed when the recipient and direct service worker were both present.

Environmental Accessibility Adaptations

Environmental Accessibility Adaptations are physical modifications to the private residence or vehicle of the recipient or his/her family that are necessary to ensure the health, welfare, and safety of the recipient or that enable the recipient to function with greater independence in the home and/or community, and without these services, the recipient would require additional supports or institutionalization.

Environmental Accessibility Adaptations may include the following:

- Installation of non-portable ramps and grab-bars,
- Widening of doors,
- Modification of bathroom facilities,
- Installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies for the welfare of the recipient, and
- Adaptations to the vehicle may include a lift, or other adaptations to make the vehicle accessible to the recipient, or for the recipient to drive.

Modifications may be applied to rental or leased property with the written approval of the landlord and approval of the OCDD regional waiver office or Human Services Authority or District.

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 Environmental Accessibility Adaptation providers must be registered through 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 environmental accessibility adaptations 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 recipient, including, but not limited to the following:

- Flooring (carpet, wood, vinyl, tile, stone, etc.),
- Interior/exterior walling not directly affected by a modification,
- Lighting or light fixtures, which are for non-medical use,
- Furniture,
- Roofing, installation or repairs, this also includes covered ramps, walkways, parking areas, etc.,
- Air conditioning or heating (solar, electric, or gas; central, floor, wall, or window units, heat pump-type devices, furnaces, etc.),
- Exterior fences or repairs made to any such structures,
- Motion detector or alarm systems for fire, security, etc.,
- Fire sprinklers, extinguishers, hoses, etc.,
- Pools,
- Smoke 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 a modification, 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),
- Adaptations, which add to the total square footage or add total living area under the roof of the residence,
- Repairs to the home or adaptations to the vehicle provided under the NOW, or
- 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 facility 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, but in any situation must pay for a specific approved adaptation. 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 $7,000 per recipient for environmental accessibility adaptations. Once a recipient reaches 90 percent or greater of the cap, and the account has been dormant for three years, the recipient may access another $7,000. Any additional environmental accessibility expenditures during the dormant period will reset the three-year time frame.

Authorization to Exceed Cap

On a case-by-case basis, with supporting documentation and based on need, a recipient may exceed the cap with prior approval from the OCDD Central Office. The support coordinator will assist the recipient 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 OCDD regional waiver office for prior authorization. The support coordinator will assist the recipient 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 OCDD regional waiver office or Human Services Authority or District must approve the request prior to any work being initiated.

The environmental accessibility adaptation, whether from an original claim, corrected claim, resubmit or revision to the Plan of Care, must be accepted by the recipient, fully delivered, installed, operational, and reimbursed in the current Plan of Care year in which it was approved. Payment will not be authorized until written documentation which demonstrates that the job is completed to the satisfaction of the recipient has been received by the support coordinator.

Upon completion of the work and prior to payment, the provider shall give the recipient 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 OCDD regional waiver office before approving modifications for a recipient leaving an ICF/DD.

Specialized Medical Equipment and Supplies

Specialized Medical Equipment and Supplies (SMES) are specified devices, controls, or appliances, which enable recipients 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:

- Sip and puffer switches,
- Specialized switches,
- Voice activated, light activated, or motion activated devices to access the recipient's environment,
- Generators for recipients whose medical condition warrants such an item, such as recipients who require ventilators,
- Items medically necessary for life support, and
- 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 OCDD regional waiver office or the Human Services Authority or District. 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 a Durable Medical Equipment (DME) 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 recipient, such as:

- Appliances (washer, dryer, stove, dishwasher, vacuum cleaner, etc.),
- Daily hygiene products (deodorant, lotions, soap, toothbrush, toothpaste, feminine products, Band-Aids, Q-tips, etc.),
- Rent subsidy,
- Food, bed covers, pillows, sheets etc.,
- Swimming pools, hot tubs etc.,
- Eye exams,
- Athletic and tennis shoes,
- Automobiles,
- Van lifts for vehicles that do not belong to the recipient or his/her family,

- Adaptive toys or recreation equipment (swing set, etc.),
- Personal computers and software,
- Exercise equipment,
- Taxi fares, intra and interstate transportation services, and bus passes,
- Pagers, including monthly service,
- Telephones, including mobile telephones and monthly service, and
- 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 recipient 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 DME through the Medicaid State Plan.

Service Limitations

There is a cap of $1,000 per recipient for specialized medical equipment and supplies. Once a recipient reaches 90 percent or greater of the cap and the account has been dormant for three years, the recipient may access another $1,000.

Any additional specialized medical equipment and supplies expenditures during this dormant three-year period resets the three-year time frame.

Authorization to Exceed Cap

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

Personal Emergency Response Systems

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

- Have a demonstrated need for quick emergency back-up,
- Are unable to use other communication systems as the systems are not adequate to summon emergency assistance, or
- Do not have 24 hour direct supervision (such as IFS or other paid supports).

The recipient 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 recipient to use the equipment.

Standards

The provider must be an enrolled Medicaid provider of the Personal Emergency Response System. 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 recipient 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 Rate and Billing Code information)

Professional Services

Professional Services are designed to increase the recipient's independence, participation and productivity in the home, work and community. Recipients, 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.

Professional Services may be utilized for the following:

- Performing assessments and/or re-assessments and recommendations,
- Providing consultative services and recommendations,
- 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 recipient or maintained according to the recipient's needs,
- Intervening in and stabilizing a crisis situation, behavioral or medical that could result in the loss of home and community-based services, or
- Providing necessary information to the recipient, family, caregivers and/or team to assist in the implementation of plans according to the approved Plan of Care.

Professional Services include psychological, social work, and nutritional services that assist the recipient, and unpaid/paid caregivers in carrying out the approved Plan of Care and which are necessary to improve the recipient's independence and inclusion in his/her 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 recipient 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 recipient.

Psychological Services include the following:

- Counseling (a variety of techniques and procedures used by the therapist, e.g., structuring and reinforcement, social modeling, and functional activities)
- Behavior evaluation for the purpose of therapy,
- Intervening and stabilizing a crisis situation,
- Ongoing therapeutic support,
- Ongoing behavior training for staff and/or families,
- Administering and interpreting tests and measurements within the scope of practice of behavior therapy,

- Administering, evaluating, and modifying treatment and consulting within the scope of practice of behavior therapy,
- Adapting environments specifically for the recipient, and
- 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 recipients with developmental disabilities. Counseling may address areas such as human sexuality, depression, anxiety disorders, and social skills. Services must only address the recipient's personal outcomes and goals listed in his/her approved Plan of Care.

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 recipient. 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 recipient's diet, and as necessary suggesting modifications to the recipient's diet.

Reimbursement will be available for the service provided directly to the recipient 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 Personal Care Attendant agency, Supported Independent Living agency, or Home Health agency to provide this service.

Providers must be licensed by the Louisiana Department of Health and Hospitals and enrolled as a waiver service provider of Personal Care Attendant, Supported Independent Living, or Home Health services.

Agencies enrolled as both Supported Independent Living and Personal Care Attendant provider types shall bill these professional services under their Personal Care Attendant number in accordance with the requirements of the fiscal intermediary. Agencies enrolled as only Supported Independent Living or Home Health providers shall bill under their Supported Independent Living or Home Health provider number.

Service Exclusions

The following activities are not reimbursable:

- Friendly visiting, attending meetings,
- Time spent on paperwork or travel,
- Time spent writing reports and progress notes,
- Time spent on billing of services, and
- 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 recipient's Plan of Care.

Service Limitations

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

A recipient 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: Day Habilitation, Transportation for Day Habilitation, Supported Employment models, Transportation for Supported Employment models, Employment-Related Training, Individual and Family Support – Day/Night/Shared, Skilled Nursing Services, or Center-Based Respite.

In order to bill for this service, the recipient 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 recipient's approved Plan of Care.

Skilled Nursing is designed to meet the needs of the recipient, to prevent institutionalization, and teach the recipient 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 recipients who require short term nursing consultations for family training, skill development etc., as specified in the recipient's approved Plan of Care.

All Medicaid State Plan services must be utilized before accessing this service. Recipients under the age of 21 must access skilled nursing services as outlined on the Plan of Care through the Home Health Program.

Shared Supports

Skilled Nursing may be shared when there is more than one recipient in the home receiving these services. Payment for shared services must be coordinated with the service authorization system and specified in each recipient's approved Plan of Care.

Standards

The provider must possess a current valid license as a home health agency by the Louisiana Department of Health and Hospitals and be enrolled as a Medicaid waiver provider of Home Health.

Service Exclusions

Skilled Nursing will not be reimbursed when the recipient 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: Transportation for Day Habilitation, Transportation for Supported Employment, Professional Services, Individualized and Family Support – Day/Night/Shared, or Center-Based Respite.

Both the recipient 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 OCDD regional waiver office or Human Services Authority or District. All requests received for more than 12 hours per day must be approved by the Department of Health and Hospitals (DHH) Medical Director and Medical Evaluation Team and will be forwarded to the OCDD regional waiver office or Human Services Authority or District 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 recipient 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 recipients, age 18 and older, who are transitioning from an Intermediate Care Facility for People with Developmental Disabilities (ICF/DD) to their own home or apartment in the community of their choice.

The recipient’s home is defined as the recipient'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:

- The purchase of essential furnishings such as
    - Bedroom and living room furniture,
    - Table and chairs,
    - Window blinds,
    - Eating utensils,
    - Food preparation items, and
    - Bed/bath linens.

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

- Moving expenses required to occupy and use a community domicile,
- Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy, and
- 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 Louisiana Department of Health and Hospitals, Office for Citizens with Developmental Disabilities (OCDD) with coordination of appropriate entities.

Service Exclusions

The following expenses are not covered under One-Time Transitional Services:

- Payments for housing or rent,
- Payments for regular utility charges,
- Household appliances/items that are intended for purely divisional/recreational purposes,
- Refundable security deposits,
- Food purchases, and
- 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 recipient. Service authorization and transitional expenses are time limited.

Housing Stabilization Transition Service and Housing Stabilization Service

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

Housing Stabilization Transition Service

Housing stabilization transition enables recipients who are **transitioning into a PSH unit**, including those transitioning from institutions, to secure their own housing. The service is provided while the recipient is in an institution and preparing to exit the institution using the waiver. The 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 Plan of Care and incorporating elements of the housing support plan, and

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

Housing Stabilization Service

Housing stabilization services enable waiver recipients to **maintain their own housing** as set forth in the recipient's approved Plan of Care. Services must be provided in the home or a community setting. 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.

- Participating in the development of the Plan of Care, incorporating elements of the housing support plan.

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

    - Includes short and long-term measurable goals for each issue,
    - Establishing the recipient's approach to meeting the goal(s), and
    - Identifying where other provider(s) or services may be required to meet the goal(s).

- 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.

- 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.
- Providing supports to retain housing or locate and secure housing if at any time the recipient'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 DHH 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 recipients 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 Plan of Care year 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 recipient.

Payment will not be authorized until the final Plan of Care approval is received.

The OCDD regional waiver office reviews all documents to ensure all requirements are met. If all requirements are met, the support coordinator provides a copy of the approved Plan of Care 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.