COVERED SERVICES

The Residential Options Waiver (ROW) services must be provided in accordance with the service criteria defined in this section, the Centers for Medicare and Medicaid Services (CMS) approved 1915(c) Medicaid Waiver application, state rule, and in the Louisiana Medicaid State Plan and in conjunction with the beneficiary's approved Plan of Care (POC).

ROW services are provided with the goal of promoting independence through strengthening the beneficiary's capacity for self-care, self-sufficiency, and community integration utilizing a wide array of services, supports, and residential options. ROW is person-centered and incorporates the beneficiary's support needs and preferences, while supporting dignity, quality of life, and security with the goal of integrating the beneficiary into the community.

Beneficiaries must be able to choose to receive services and supports from any provider in their region listed on the Freedom of Choice (FOC) listing. Direct service providers cannot offer FOC to beneficiaries.

Under no circumstance may a service provider or a direct service worker charge beneficiaries, their authorized representative, their family member(s), or other support team members a separate transportation fee or any other fee for covered services.

ROW services are provided as a supplement to regular Medicaid State Plan services and natural supports and should not be viewed as a lifetime entitlement or a fixed annual allocation. The average beneficiary expenditures for all waiver services shall not exceed the average Medicaid expenditures for Intermediate Care Facilities for Individuals with Intellectual Disabilities, (ICF/IID) services.

All ROW beneficiaries must receive a residential service (community living supports (CLS), companion care, host home, shared living, or monitored in-home caregiving) and support coordination services. Other services are to be selected based on a beneficiary's need/want and individual budget.

Beneficiaries must receive a residential service and support coordination at least once every 30 days.

Providers must be licensed by the Louisiana Department of Health as a Home and Community-Based Waiver Services provider and meet the module specific requirements in LAC 48:I. Chapter 50. (Refer to the Appendix C).

Support Coordination

Support Coordination consists of the coordination of supports and services that will assist beneficiaries who receive ROW services in gaining access to needed waiver and Medicaid State Plan services as well as to needed medical, social, educational, and other services, regardless of the funding source.

Beneficiaries/families choose a support coordination agency through the Freedom of Choice listing provided by the Medicaid data contractor upon acceptance of a waiver opportunity.

The support coordinator is responsible for convening the person-centered planning team comprised of the:

1. Beneficiary;
2. Beneficiary's family;
3. Direct service providers;
4. Medical and social work professionals, as necessary; and
5. Advocates, who assist in determining the appropriate supports and strategies to meet the beneficiary's needs and preferences.

Support Coordinator

The support coordinator shall be responsible for the ongoing supports, assistance, and coordination and the monitoring of supports and services included in the beneficiary's POC. Support Coordination services include:

1. Assistance with the selection of service providers;
2. Development and revision of the POC; and
3. Participation in the evaluation and re-evaluation of the beneficiary's POC.

When beneficiaries choose the Self-Direction Option for service delivery, Support Coordination services provide information, assistance, and management of the service being self-directed. This includes assisting the beneficiary in reviewing, understanding, and completing the activities as identified in the *Self-Direction Employer Handbook.* The support coordinators will be available

to beneficiaries for on-going support and assistance in the following decision-making areas, as well as for employer responsibilities:

1. Recruitment techniques, interviewing strategies, hiring and termination of staff;
2. Verification of employee qualifications;
3. Orienting and instructing staff in duties;
4. Scheduling staff;
5. Reviewing/approving employee timesheets documentation;
6. Conducting employee performance evaluations; and
7. Reviewing/approving provider invoices.

Service Limitations

1. Support Coordination shall not exceed 12 units per year. A unit is considered a month;
2. If criteria identified are met, 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; and
3. When a relative living in the home or a legally responsible individual or legal guardian provides a paid ROW service, all support coordination visits must be conducted face-to-face, with no option for virtual visits.

Community Living Supports

CLS are provided to a beneficiary in their own home and in the community to achieve and/or maintain the outcomes of increased independence, productivity, and enhanced family functioning; to provide relief of the caregiver, and to ensure inclusion in the community. CLS focus on the achievement of one or more goals as indicated in the beneficiary's approved POC by incorporating teaching and support strategies. Supports provided are related to the acquisition, improvement, and maintenance of independence, autonomy, and adaptive skills. The overall goal for each beneficiary is to obtain or maintain his or her level of independence, level of productivity, and involvement in the community as outlined in each beneficiary's approved POC. Individual specific goals are identified in the POC and provided by the beneficiary’s direct support worker.

Supports provided include the following:

Self-Help Skills:

1. Activities of daily living and self-care (i.e., bathing, grooming, dressing, nutrition, money management, laundry, travel training, and safety skills);

2. Skills intended to increase level of independence; and

3. Travel-training to community activities/locations (not intended to be used when the beneficiary is learning to go to and from a vocational setting).

Socialization Skills:

1. Appropriate communication with others, both verbal and nonverbal (i.e., manners, making eye contact, shaking hands, and behavior); and

2. Skills intended to increase involvement in the community (i.e., church membership, voting, participation in sports, and volunteering).

Cognitive and Communication Tasks:

1. Learning activities - (i.e., attention to task, self-control, verbal/nonverbal communication, and interpersonal communication-verbal/nonverbal cues); and

2. Tasks intended to increase level of understanding and to communicate more effectively.

Acquisition of Appropriate, Positive Behavior:

1. Appropriate behavior – (i.e., non-aggression and appropriate social interaction); and

2. Intended to increase socially appropriate behavior.

CLS providers are to work collaboratively to identify specific training opportunities based on the beneficiary's daily routine, need, and level of interest with the beneficiary's:

1. Natural supports;

2. Support coordinator;

3. Vocational provider; and/or

4. Professional provider.

Training components can include:

1. Self-help skills;

2. Socialization skills;

3. Cognitive and communication skills; and

4. Acquisition of appropriate/positive behavior.

CLS may be a self-directed service and family members who provide CLS must meet the same standards as unrelated provider agency staff.

Community Living Supports (Shared Supports)

CLS may be shared by up to three beneficiaries who may or may not live together and who have a common direct service provider. In order to share CLS, beneficiaries and their family/legal guardians must agree. In addition, CLS Direct Support Staff may be shared across the Children's Choice or New Opportunities Waiver (NOW) at the same time. The health and welfare of each beneficiary must also be assured. Shared staff must be reflected in each beneficiary's POC and be based on an individual basis. A shared rate is billed when beneficiaries share CLS.

CLS services are furnished to adults and children who live in a home that is leased or owned by the beneficiary or his or her family. Services may be provided in the home or community, with the place of residence as the primary setting.

When this service is provider managed, the provider has 24-hour responsibility to deliver back-up and emergency staff to meet unpredictable needs of the beneficiary in a way that promotes maximum dignity and independence while enhancing supervision, safety, and security.

When the self-directed option is utilized, the beneficiary must have an individualized back-up plan and evacuation plan, both of which must be submitted with the POC for review and approval. The direct support workers must meet minimum qualifications.

Transportation

The cost of transportation is built into the CLS rate and must be provided when it is integral to CLS. Transportation-Community Access service can be utilized by CLS beneficiaries as long as Transportation-Community Access is not billed at the same time as CLS.

Service Units and Limitations

1. The CLS Service Unit is 15 minutes;

2. Family members who provide CLS services must meet the same standards as providers who are unrelated to the beneficiary. Service hours shall be capped at 40 hours per week/per staff, Sunday to Saturday, for services delivered by family members or legally responsible individuals living in the home;

3. Legally responsible individuals (such as a parent or spouse) and legal guardians may provide CLS 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;

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

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

6. Payment does not include room and board, maintenance, upkeep, and/or improvement of the beneficiary's or family's residence;

7. CLS staff providing services are not allowed to sleep during billable hours of zcls;

8. Provider may not bill for CLS for the same time on the same day as respite services;

9. CLS are not available to individuals receiving Shared Living Services, Host Home Services, or Companion Care Services (the same type of supports that CLS provides are integral to and built into the rate for these three services, and this prohibition prevents duplication of services);

10. Payment will not be made for travel training to vocational services;

11. Payment for services rendered are approved by prior and post authorization as outlined in the POC;

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

13. Both the beneficiary and the 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;

14. Services cannot be provided "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 LGE office and included in the beneficiary's POC;

15. Services are not allowed to be provided in the non-related DSW place of residence; and

16. CLS is not intended to provide continuous 24 hours a day on-to-one support.

CLS services may not be provided in the following locations:

1. A hospital, once the beneficiary has been admitted for inpatient services; or

2. 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 CLS services. Time spent off the cruise ship and in a foreign country or territory is not eligible for CLS services. Tickets for these types of trips should not be purchased until a revision to POC has been approved by the LGE office. Beneficiary funds are not allowed to be used to purchase travel tickets for direct service workers accompanying the beneficiary on the trip without written approval from the LGE office.

CLS cannot be provided or billed for at the same time on the same day as:

1. Supported Employment;

2. Day Habilitation;

3. Prevocational Services;

4. Respite Care Services-Out of Home;

5. Transportation-Community Access;

6. Monitored in-home caregiving (MIHC);

7. Adult Day Health Care;

8. Companion Care; or

9. Community Life Engagement Development.

NOTE: Payment will not be made for transportation to and from Supported Employment, Day Habilitation, or Prevocational Services, as transportation for these services are included in the rate for each vocational service.

Reimbursement

The use of the EVV system is mandatory for CLS Services. The EVV system requires the electronic check in/out in the Louisiana Services Reporting System (LaSRS®) or another EVV system approved by BHSF and OCDD

Host Home Services

Host Home services are a residential option available to beneficiaries who wish to live in a family setting when residing with their immediate family is not an option. Host Home services are available to beneficiaries of any age and take into account individual compatibility, which includes individual interests, age, privacy needs, and supervision/support needs.

Personal care and supportive services are provided to a beneficiary who lives in a private home with a family who is not the beneficiary's parent, legal representative, or spouse. Host Home Families are a stand-alone family living arrangement in which the principle caregiver in the Host Home assumes the direct responsibility for the beneficiary's physical, social, and emotional well-being and growth in a family environment.

The Host Home Family provides the beneficiary with a welcoming, safe, and nurturing family environment. In addition, the beneficiary is provided any assistance needed with activities of daily living and support. Community activities identified in the beneficiary's POC are also encouraged and supported.

Host Home services include assistance with:

1. Personal care – assistance with the activities of daily living and adaptive living needs;

2. Leisure activities – assistance to develop leisure interests and daily activities in the home setting;

3. Social development/ family inclusion – assistance to develop relationships with other members of the household; and

4. Community inclusion - supports in accessing community services, activities and pursuing and developing recreational and social interests outside the home.

Natural supports are also encouraged and supported when possible. Supports are to be consistent with the beneficiary's skill level, goals, and interests.

Place of Service

The primary setting of service is considered to the Host Home Family residence. The Host Home Family must own, rent, or lease its place of residence. The Host Home Family can also provide supports and services in the community setting as indicated in the beneficiary's POC.

Service Units and Limitations

1. Service Unit for Host Home services is a per-diem rate based on the beneficiary's Inventory for Client and Agency Planning (ICAP);

2. Children eligible for Title IV-E services are not eligible for Host Home services;

3. Regardless of the funding source, a Host Home Family shall not have more than two people for whom the Host Home Family is receiving compensation; and

4. Host Home Families must not allow more than three persons unrelated to the principal caregiver to live in the home.

Services Exclusions

1. Payment is not made for room and board or maintenance, upkeep, or improvement of the Host Home Family's residence;

2. Separate payment will not be made for the following services:

a. CLS;

b. Respite Care Services-Out of Home;

c. Shared Living/Shared Living Conversion;

d. Companion Care;

e. Monitored in Home Caregiving;

f. Transportation-Community Access;

g. Environmental Accessibility Adaptations; or

h. One-Time Transitional Services.

3. The Host Home Family may not be the owner or administrator of the Host Home Provider agency in order to prevent a conflict of interest.

4. Payment will not be made for services provided by a relative who is a:

a. Parent(s) of a minor child;

b. Legal guardian of an adult or child with developmental disabilities;

c. Parent(s) for an adult child regardless of whether or not the adult child has been interdicted; or

d. Spouse of the beneficiary.

Companion Care Services

Companion Care Services are a residential option available to beneficiaries who do not typically require 24-hour supports. Companion care services focus on assisting the beneficiary in achieving and/or maintaining increased independence, productivity, and community inclusion as identified in the beneficiary's POC.

Beneficiaries in this residential option receive supports provided by a companion who lives in the residence as the beneficiary’s roommate. The companion provides personal care and support services to a beneficiary who resides as a roommate with their caregiver. An agreement is developed between the beneficiary and the companion that outlines the specifics of the arrangement.

This residential option is most feasible for adults (aged 18 and older) who either own their own home or who rent. Companion Care Services are designed to support beneficiaries who are able to manage their own household with the need for only limited supports.

Companion Care Services:

1. Focus on assisting the beneficiary to achieve and/or maintain the outcomes of increased independence, productivity and inclusion in the community;

2. Provide assistance with the activities of daily living as indicated in the beneficiary's POC;

3. Provide assistance with community access and coordination of transportation, including medical appointments;

4. Participate in, and follow, the beneficiaries POC and any other support plans;

5. Provide assistance/support consistent with the beneficiary's goals as identified in the beneficiary's POC; and

6. Maintain documentation /records in accordance with State and provider requirements.

Companion Care Services are provided by a companion (roommate) who:

1. Must be at least 18 years of age;

2. Must live with the beneficiary;

3. Must purchase personal food and personal care items;

4. Is a contracted employee of the provider agency and is paid a flat daily rate to provide limited, daily direct services as negotiated with the beneficiary;

5. Is available in accordance with a pre-arranged time schedule as outlined in the beneficiaries POC;

6. Is available 24 hours a day (by phone contact) to the beneficiary to provide supports on short notice as a need arises and for crisis support to ensure the health and safety of the beneficiary;

7. Legally responsible individuals and legal guardians may provide Companion Care services for a beneficiary provided; and

8. When the beneficiary requests the person as a roommate, living responsibilities and finances in the home are divided and shared with the provider agency, the care is provided in the beneficiary's residence and this service is in the best interest of the beneficiary,

Beneficiary/Companion Agreement

The Beneficiary/Companion Agreement is developed between the beneficiary and companion to identify the specific type(s) of assistance that the beneficiary needs both in the home setting and in the community that the companion is to provide. The agreement also includes responsibilities which are to be shared by the beneficiary and companion. It also includes a typical weekly schedule.

The provider assists by facilitating the development of the written agreement. The agreement then becomes part of the beneficiary's POC. Revisions to the Beneficiary/Companion Agreement must be facilitated by the beneficiary's provider and approved by the POC team. Revisions may occur at the request of the beneficiary, the companion, the provider, or the beneficiary's support team.

Place of Service

Companion Care services are delivered in the beneficiary's home. The companion also supports the beneficiary by assisting the beneficiary in the community as indicated in the beneficiary's POC and in the Beneficiary/Companion Agreement.

Service Units and Limitations

1. Service Unit is a per-diem rate based on the Beneficiary's ICAP.

Service Exclusions

1. Companion Care is not available to individuals receiving the following services:

    a. Respite Care Services- out of home;

    b. CLS;

    c. Host Home;

    d. Shared Living Services;

e. Monitored in Home Caregiving; or

f. Transportation-Community Access.

2. Companion Care services are not available to beneficiaries under the age of 18;

3. Payment does not include room and board or maintenance, upkeep, or improvement of the beneficiary's or the provider's property;

4. Transportation for vocational services are to be billed by vocational providers; and

5. The Companion Care provider's rate includes funding for relief staff for scheduled and unscheduled absences.

Shared Living Services

Shared Living Services are provided to a beneficiary in their home and community to achieve, improve, and/or maintain social and adaptive skills necessary to enable the beneficiary to reside in the community and to beneficiary as independently as possible. Shared Living services focus on the beneficiary's preferences and goals. The overall goal is to provide the beneficiary the ability to successfully reside with others in the community while sharing supports.

A Shared Living Provider delivers supports which include:

1. 24-hour staff availability;

2. Assistance with all activities of daily living (ADLs) as needed and indicated in the POC;

3. A daily schedule;

4. Health and welfare needs;

5. Transportation;

6. Any non-residential ROW services delivered by the shared living services provider; and

7. Other responsibilities as required in each beneficiary's POC.

Supports provided are related to the acquisition, improvement, and maintenance in level of independence, autonomy, and adaptive skills and are to be included in each beneficiary's POC. This includes:

1. Self-care skills;
2. Adaptive skills; and
3. Leisure skills.

Shared Living services take into account the compatibility of the beneficiaries sharing services, which includes:

1. Individual interests;
2. Age of the beneficiaries; and
3. Privacy needs of each beneficiary. Each beneficiary's essential personal rights of privacy, dignity and respect, and freedom from coercion are protected.

The Shared Living setting is selected by each beneficiary among all available alternatives and is identified in each beneficiary's POC. The following is also assured for each beneficiary:

1. Each beneficiary has the ability to determine whether or with whom they share a room;
2. Each beneficiary has the freedom of choice regarding daily living experiences, which include meals, visitors, and activities; and
3. Each beneficiary is not limited in opportunities to pursue community activities.

Shared Living services may be shared by up to four beneficiaries who have a common Shared Living provider agency

Shared Living services must be agreed upon by each beneficiary, and the health and welfare must also be assured for each beneficiary. If the beneficiary has a legal guardian, their approval must also be obtained.

Each beneficiary's POC must reflect the Shared Living services and include the shared rate for the service indicated.

The Shared Living service setting is integrated into, and facilitates each beneficiary's full access to the greater community, which include:

1. Opportunities for each beneficiary to seek employment and work in competitive integrated settings and engage in community life;

2. Control of personal resources; and

3. Receipt of services in the community like individuals without disabilities.

Shared Living Services may include the Conversion Option or the New/Non-Conversion Option.

Shared Living Conversion Option

The shared living conversion option is only allowed for providers of homes that were previously licensed and Medicaid certified as an ICF/IID for up to a maximum of eight licensed and Medicaid-funded beds on October 1, 2009, and should meet the following criteria:

1. The number of beneficiaries for the shared living conversion option shall not exceed the licensed and Medicaid-funded bed capacity of the ICF/IID on October 1, 2009, or up to six individuals, whichever is less;

2. The ICF/IID used for the shared living conversion option must meet the department's operational, programming, and quality assurances of health and safety for all beneficiaries;

3. The provider of shared living services is responsible for the overall assurances of health and safety for all beneficiaries; and

4. The provider of shared living conversion option may provide nursing services and professional services to beneficiaries utilizing this residential services option.

Shared Living Non-Conversion (New) Option

The shared living non-conversion option is allowed only for new or existing ICF/IID providers to establish a shared living waiver home for up to a maximum of three individuals. The shared living waiver home must:

1. Be located separate and apart from any ICF/IID;

2. Be a home owned or leased by the waiver beneficiaries or a home owned or leased and operated by a licensed shared living provider; and

3. Meet the department's operational, programming, and quality assurances for home and community-based services.

The shared living provider is responsible for the overall assurances of health and safety for all beneficiaries.

ICF/IID providers who convert an ICF/IID to a Shared Living home via the shared living conversion model must:

1. Be approved by OCDD and licensed by HSS prior to providing services in this setting and prior to accepting any ROW beneficiary or applicant for residential or any other developmental disability service(s);

2. Shall obtain the approval of all of the residents of the home(s) (or the responsible parties for these residents) regarding the conversion of the ICF/IID prior to beginning the process of conversion; and

3. Shall submit a licensing application for an HCBS provider license, Shared Living Module.

ICF/IID Conversion

An ICF/IID may elect to permanently relinquish its ICF/IID license and all of its Medicaid Facility Need Review approved beds from the total number of Certificate of Need (CON) beds for that home and convert it into a shared living waiver home or in combination with other ROW residential options as deemed appropriate in the approved conversion agreement.

In order to convert, the provider request must be approved by the Department and by OCDD, and ICF/IID residents who choose transition to a shared living waiver home must also agree to conversion of their residence.

1. If choosing ROW services, persons may select any ROW services and provider(s) based upon freedom of choice;

2. All Shared Living service beneficiaries are required to have an individualized back-up staffing plan and an individualized emergency evacuation plan which are to be submitted with their POC;

3. Family members who provide Shared Living services must meet the same standards as unrelated provider agency staff; and

4. Shared Living service providers are responsible for providing 24-hour staff member availability along with other identified responsibilities as indicated in

each beneficiary's individualized POC. This includes responsibility for each beneficiary's routine daily schedule, for ensuring the health and welfare of each beneficiary while in his or her place of residence and in the community, and for any other waiver services provided by the Shared Living services provider.

Place of Service

Shared Living services may not be provided in a building that is a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution or a disability-specific housing complex. The Shared Living services may also not be provided in settings that are isolated from the larger community.

Shared Living services may only be provided in a residence that is owned or leased by the provider or that is owned or leased by the beneficiary. Services may not be provided in a residence that is owned or leased by any legally responsible relative of the beneficiary.

If Shared Living services are provided in a residence that is owned or leased by the provider, any modification of the conditions must be supported by specific assessed needs and documented in the beneficiary's POC. The provider is responsible for the cost of and implementation of the modification when the residence is owned or leased by the provider.

In a provider-owned or controlled residential setting, the following additional conditions must be met. Any modifications of the conditions must be supported by a specific assessed need and documented in the POC:

1. The unit or room is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the beneficiary receiving services, and the beneficiary has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant laws of the state, parish, city, or other designated entity;

2. Each beneficiary has privacy in their sleeping or living unit, which requires the following:

    a. Units have lockable entrance doors, with appropriate staff having keys to doors;

    b. Beneficiaries share units only at the beneficiary's choice; and

    c. Beneficiaries have the freedom to furnish and decorate their sleeping or living units.

3. Beneficiaries have the freedom and support to control their own schedules and activities, and have access to food at any time;

4. Beneficiaries are able to have visitors of their choosing at any time; and

5. The setting is physically accessible to the beneficiary.

Transportation

The cost of transportation is built into the Shared Living rate. As a result, Transportation-Community Access is not available to beneficiaries receiving Shared Living services.

Service Units and Limitations

Service Units are per diem with the rate based on the beneficiary's ICAP, and payments shall not:

1. Include room and board or maintenance, upkeep, or improvements of the beneficiary's or the provider's property; or

2. Be made for environmental accessibility adaptations when the provider owns or leases the residence.

Beneficiaries may receive one-time transitional services only if the beneficiary owns or leases the home and the service provider is not the owner or landlord of the home. MFP beneficiaries cannot participate in ROW shared living services which serve more than four persons in a single residence.

Transportation-community access services cannot be billed or provided for beneficiaries receiving shared living services, as this is a component of shared living services.

Service Exclusions

Shared Living services are not available to beneficiaries 17 years of age and under and beneficiaries receiving Shared Living services are not eligible to receive:

1. Respite Care Services-Out of Home;

2. Companion Care;

3. Host Home;

4. CLS;

5. Monitored in Home Caregiving;

6. Environmental Accessibility Adaptations (if housing is leased or owned by the provider); or

7. Transportation - Community Access.

The Shared Living services rate includes the cost of transportation, and the provider is responsible for providing transportation for all community activities except for vocational services. Transportation for vocational services is included in the rate of the vocational service and all Medicaid State Plan nursing services must be utilized and exhausted.

The Shared Living staff may not live in the beneficiary's place of residence, and payment will not be made for services provided by a relative who is a:

1. Parent(s) of a minor child;
2. Legal guardian of an adult or child with developmental disabilities;
3. Parent(s) for an adult child regardless of whether or not the adult child has been interdicted; or
4. Spouse of the beneficiary.

Respite Care Services – Out of Home

Respite care out of home services are provided on a temporary/short-term basis to beneficiaries who are unable to care for themselves due to the absence of or need for relief of caregivers who normally provide unpaid care and support. Services are provided by a Center-Based Respite provider in a licensed center-based respite care facility. Services are provided according to a POC that takes into consideration the specific needs of the person.

A licensed respite care facility shall ensure that community activities are available to the beneficiary in accordance with beneficiary's approved POC, including transportation to and from these activities. While receiving respite care services, the beneficiary's routine is maintained in order to attend school, school activities, or other community activities.

Community activities and transportation to and from these activities in which the beneficiary typically engages in are to be available while receiving Respite Services-Out of Home.

These activities should be included in the beneficiary's approved POC, which will provide the beneficiary the opportunity to continue to participate in typical routine activities. Transportation costs to and from these activities are included in the Respite Services-Out of Home rate.

Service Units and Limitations

Respite Care Services - Out of Home:

1. Service unit is 15 minutes;

2. Respite care services are limited to 720 hours per beneficiary, per POC year; and

3. Respite care services cannot be provided in a private residence.

NOTE: The process for approving hours in excess of 720 hours must go through the established approval process with proper justification and documentation.

Service Exclusions

1. Respite care services-out of home is not a billable waiver service to beneficiaries receiving the following services:

    a. Shared Living Services;

    b. Host Home Services;

    c. Companion Care Services; and

    d. CLS cannot be provided at the same time on the same day.

2. Respite care services-out of home cannot be provided in a personal residence; and

3. Payment will not be made for Transportation-Community Access.

Reimbursement

The use of the EVV system is mandatory for Center-Based Respite Services. The EVV system requires the electronic check in/out in the Louisiana Services Reporting System (LaSRS®) or another EVV system approved by BHSF and OCDD.

Personal Emergency Response System (PERS)

Personal Emergency Response System (PERS) service is an electronic device connected to the beneficiary's phone which enables beneficiary him/her to secure help in an emergency. This service also includes an option in which the beneficiary would wear a portable help button. The device is programmed to emit a signal to the PERS Response Center where trained professionals respond to the beneficiary's emergency situation. PERS services are available to beneficiaries who meet the following criteria:

1. Have a demonstrated need for quick emergency back-up;

2. Are able to identify that they are in an emergency situation and then are able to activate the system requesting assistance;

3. Are unable to use other communication systems as the systems are not adequate to summon emergency assistance; and

4. Are unable to summon assistance by dialing 911, or other emergency services available to the general public.

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:

1. The initial installation of the equipment;

2. Training for the beneficiary in the use of the device;

3. Rental of the device/electronic help button;

4. Monthly maintenance fees; and

5. Enhance Services- Mobile Emergency Response System- an on-the go mobile medical alert system, used in and outside the home:

    a. This system will have cellular/GPS technology, two-way speakers and no base station will be required; and

    b. In addition to the current system that plugs into a landline, a system that uses cellular service may be used and the landline is not required; this system will have a fall detection pendant.

The monthly fee, regardless of the number of units in the household, shall include the cost of maintenance and training the beneficiary to use the equipment.

In addition to the current system that plugs into a landline, a system that uses cellular service and the landline is not required; this system will have a fall detection pendant.

Service Units and Limitations

1. Service unit comprises initial installation and monthly service;
2. Reimbursement will be made for an installation fee for the PERS unit;
3. Coverage of the PERS is limited to the rental of the electronic device; and
4. Cell phone service is not included and is not a covered waiver service.

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).

One - Time Transitional Services

One –Time Transitional Expenses are non-reoccurring set-up expenses to assist a beneficiary 18 years of age and older, who is moving from an institutional setting to their own home in the community of their choice.

The beneficiary’s home is defined as the beneficiary's own residence and does not include the residence of any family member or a Host Home. The beneficiary’s support coordinator assists in accessing funds and making arrangements in preparation for moving into the residence. Beneficiaries have the right to choose the furnishings for their home or apartment purchased with these funds.

One-Time Transitional Services may be accessed for the following:

1. Non-refundable security deposit;
2. Utility deposits (set-up/deposit fee for telephone service);
3. Purchase of essential furnishings to establish living arrangements, including:

a. Bedroom furniture;

b. Living room furniture;

c. Table and chairs;

d. Window blinds;

e. Kitchen items (i.e., food preparation items, eating utensils); and

f. Bed/bath linens.

4. Moving expenses required to occupy and use a community domicile;
5. Health and safety assurances (i.e., pest eradication, one-time cleaning prior to occupancy; and

6. Non-refundable 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.

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

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 Units and Limitations

1. There is a one-time, life time maximum of $3,000 per beneficiary; and

2. Service expenditures must be prior authorized and tracked by the prior authorization contractor and are time limited.

Service Exclusions

One Time Transitional Services may not be used to pay for the following:

1. Housing;

2. Rent;

3. Refundable security deposits (non-refundable security deposits are not to include rental payments);

4. Household appliances/items that are intended for purely recreational purposes;

5. Furnishings or setting up living arrangements for:

   a. Residences of any family member;

   b. Persons receiving Host Home Services; or

   c. Payment for housing or rent.

6. One-time transitional services are not available to beneficiaries who are receiving host home services;

7. One-time transitional services are not available to beneficiaries who are moving into a family member's home; and

8. One-time Transitional Services may not be used to pay for furnishings or setting up living arrangements that are owned or leased by a waiver provider.

Environmental Accessibilities Adaptations

Environmental Accessibilities Adaptations are physical adaptations to the beneficiary's home or vehicle which are necessary to ensure the beneficiary's:

1. Health;

2. Welfare;

3. Safety; and

4. Ability to function with greater independence in the home without which the beneficiary would require additional supports or institutionalization.

Prior to the beneficiary receiving any environmental adaptation, an evaluation is to be completed by an occupational therapist and/or a physical therapist. The therapist is to assess for need and type of device/adaptation and is to make a recommendation regarding the specific environmental adaptation necessary to address the identified needs of the beneficiary.

All environmental accessibilities adaptations are to be included in the beneficiary's POC, and all environmental adaptations to the home and vehicle must meet all applicable standards of manufacture, design, and installation.

NOTE: Reimbursement shall not be paid until receipt of written documentation that the job has been completed to the satisfaction of the beneficiary/family.

Home Adaptations

Home Adaptations pertain to modifications that are made the beneficiary's primary residences. Such adaptations to the home may include:

1. Bathroom modifications;

2. Ramps;

3. Other adaptations to make the home accessible to the beneficiary;

4. Performance of necessary assessments in addition to occupational therapy/physical therapy evaluations that may be necessary to determine the types of modifications that are necessary;

5. Installation of:

    a. Ramps and grab-bars;

    b. Widening of doorways;

    c. Modification of bathroom facilities; or

    d. Installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the beneficiary.

6. Training the beneficiary and provider in the use and maintenance of the Environmental Adaptation (s);

7. Repair of all equipment and/or devices, including battery purchases and other reoccurring replacement items that contribute to the ongoing maintenance of the adaptation(s); and

8. Standard manufacturer provided service contracts and other warranties from manufactures and providers related to the environmental adaptations.

NOTE: All Environmental Accessibility Adaptations to the home must meet all applicable standards of manufacture, design, and installation and the service must be for a specifically approved adaptation.

Place of Service

Home adaptation services are provided at the beneficiary's home and may not be furnished to adapt living arrangements that are owned or leased by waiver providers; and modifications may be applied to rental or leased property only with the written approval of the landlord and approval of the LGE.

Service Units and Limitations for Home Adaptation

1. Service unit is determined per item/service;

2. All adaptations must meet all applicable standards of manufacture, design, and installation;

3. Home modification funds are not intended to cover basic construction costs;

4. Waiver funds may be used only to pay the cost of purchasing specific approved adaptations for the home, not for construction costs of additions to the home;

5. Home modification funds may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services;

6. Home modification funds may not include modifications which add to the total square footage of the home except when the additional square footage is necessary to make the required adaptations function appropriately (e.g., if a bathroom is very small and a modification cannot be done without increasing the total square footage, this would be considered an approvable cost);

7. When new construction or remodeling is a component of the service involved, payment for the service is to only cover the difference between the cost of typical construction and the cost of specialized construction for the person with the disability; and

8. Home modification requests with costs exceeding $20,000 should be sent to the State Office Review Committee (SORC) for review recommendations and approval.

Services Exclusions for Home Adaptation

Home modification adaptations may not include modifications to the home which are of general utility and are not of direct medical or remedial benefit to the beneficiary, including but not limited to:

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

2. Roofing installation or repairs, including also covered ramps, walkways, parking areas, etc.;

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

4. Hot tubs;

5. Swimming pools;

6. General home repair and maintenance;

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

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

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

10. Furniture;

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

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

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, etc.);

15. Repairs or modifications provided to previously installed home modifications not provided under the ROW;

16. Smoke and carbon monoxide detectors;

17. Interior/exterior non-portable oxygen sites; or

18. Whole home (gas/electrical) generators.

Home modification funds may not be furnished to adapt living arrangements that are owned or leased by paid caregivers or providers of waiver services and cannot pay for in provider-owned settings, such as Host Homes and provider-owned or leased Shared Living settings.

Home modification funds may not be used for service warrants and contracts above those provided by the manufacturer at the time of purchase (e.g. extended warranties, extended service contracts).

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 LGE must approve the "Environmental Modifications Job Completion Forms" (Form-PF-01-010).

Upon completion of the work and prior to payment, the provider shall give the beneficiary a certificate of warranty for all labor and installation and all warranty certificates from manufacturers. The warranty for labor and installation must cover a period of at least six (6) months. Payment will not be authorized until written documentation that demonstrates that the job has been completed to the satisfaction of the beneficiary has been received by the support coordinator.

The Environmental Accessibility Adaptation must be accepted by the beneficiary and fully delivered, installed, operational, and reimbursed in the current POC year in which it was approved. The support coordinator must contact the LGE before approving modifications for a beneficiary leaving an ICF/IID.

Vehicle Adaptations

Vehicle Adaptations pertain to modifications to a vehicle that is the beneficiary's primary means of transportation in order to accommodate their special needs. Vehicle Adaptations must be specified in the POC as necessary to enable the beneficiary to integrate more fully into the community and to ensure the health, welfare and safety of the beneficiary.

Vehicle Adaptations may include:

1. The performance of necessary assessments in addition to occupational therapy/physical therapy evaluations to determine the types of modifications that are necessary;

2. A lift or other adaptations to make the vehicle accessible to the beneficiary or to make the vehicle accessible for the beneficiary to drive;

3. Training the beneficiary and provider in the use and maintenance of the adaptation;

4. Repair of all equipment and/or devices, including battery purchases and other reoccurring replacement items that contribute to the ongoing maintenance of the adaptation(s); and

5. Provision of service contracts and other warranties from manufactures and providers related to the Vehicle Adaptations.

Vehicle modifications must meet all of the applicable standards of manufacture, design, and installation for all adaptations to the vehicle.

Service Units and Limitations

1. Service unit is determined per service, and this service must be for a specific approved adaptation; and

2. Vehicle modification requests with cost exceeding $20,000 should be sent to State Office Review Committee (SORC) for review recommendations and approval.

Service Exclusions for Vehicle Adaptations

The following vehicle adaptations are excluded:

1. Adaptions to vehicles that are owned or leased by a paid caregiver or by providers of waiver services;

2. Modifications which are of general utility and are not of direct medical or remedial benefit to the beneficiary;

3. Purchase or lease of a vehicle;

4. Regularly scheduled upkeep and maintenance of a vehicle, except for upkeep and maintenance of the modifications;

5. Service warranties and contracts above those provided by the manufacturer at the time of purchase (e.g., extended warranties, extended service contracts); and

6. Car seats.

Overall budget of service and frequency required for an individual in the ROW should allow for two (2) waiver services every 30-days. Budget should allow for unanticipated increases in service needs due to changing needs and emergency situations. Exhausting budget funds for environmental accessibility adaptations is not justification to suspend the 30-day rule.

A written, itemized, and detailed bid must be obtained and submitted to the LGE for prior authorization. The LGE must approve the "Environmental Modifications Job Completion Forms."

Upon completion of the work and prior to payment, the provider shall give the beneficiary a certificate of warranty for all labor and installation and all warranty certificates from manufacturers. The warranty for labor and installation must cover a period of at least six (6) months. Payment will not be authorized until written documentation that demonstrates that the job has been completed to the satisfaction of the beneficiary has been received by the support coordinator.

The Environmental Accessibility Adaptation must:

1. Be accepted by the beneficiary;

2. Fully delivered, installed, operational; and

3. Reimbursed in the current POC year in which it was approved.

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

Reimbursement

Environmental Accessibility Adaptations items reimbursed through ROW funds shall be supplemental to any adaptations furnished under the Medicaid State Plan.

The environmental accessibility adaptation must be accepted by the beneficiary and be 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 coordinator must contact the LGE before completing any home modification for a beneficiary leaving an ICF/IID.

Assistive Technology/Specialized Medical Equipment and Supplies

Assistive Technology/Specialized Medical Equipment and Supplies (AT/SMES) service includes providing specialized devices, controls, or appliances that enable a beneficiary to increase their ability to perform activities of daily living, ensure safety, and/or perceive, control, and communicate within their environment. These services also include medically necessary durable and non-durable medical equipment not available under the Medicaid State Plan, repairs to such items, and equipment necessary to increase/maintain the independence and well-being of the beneficiary.

All equipment, accessories and supplies must meet all applicable manufacture, design, and installation requirements. The services under the ROW are limited to additional services not otherwise covered under Medicaid State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. (Must first access and exhaust items furnished under State Plan). The ROW will not cover items that are not considered medically necessary. This service includes items that meet at least one of the following criteria:

1. Items that are necessary for life support;

2. Items that are necessary to address physical conditions, along with ancillary supplies;

3. Items that will increase ability to perform activities of daily living;

4. Items that will increase, maintain, or improve ability to function more independently in the home and/or community;

5. Items that will increase the beneficiary's ability to perceive, control, or communicate within their environment;

6. Equipment necessary to the proper functioning of such items to address physical conditions; and

7. Necessary medical supplies that are not available under the State Plan.

Prior to the beneficiary receiving any Assistive Technology device, an evaluation is to be completed by an occupational therapist and/or a physical therapist. The therapist is to assess for need and type of device and is to make a recommendation regarding the specific Assistive Technology device necessary to address the identified needs of the beneficiary. AT/SMES are to be included in the beneficiary's POC.

Assistive Technology/Specialized Medical Equipment and Supplies provided through the ROW include the following services:

1. Evaluation of the assistive technology needs of a beneficiary, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the beneficiary in the customary environment of the beneficiary in addition to occupational therapy/physical therapy evaluations;

2. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

3. Purchasing, leasing or otherwise providing for the acquisition of assistive technology devices for the beneficiary;

4. Training or technical assistance on the use and maintenance of the equipment or device for the beneficiary, or, where appropriate, their family members, guardians, advocates, or authorized representatives of the beneficiary, professionals, or others;

5. Training or technical assistance for professionals or other individuals who provide services to, employ, or who are otherwise substantially involved in the major life functions of the beneficiary;

6. Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the POC;

7. Provision of service contracts and other warranties from manufactures and providers related to the AT/SMES;

8. All service contracts and warranties included in the purchase of the item by the manufacturer; and

9. Equipment or device repair and replacement of batteries and other reoccurring replacement items that contribute to ongoing maintenance of these devices.

   NOTE: Separate payment will be made for repairs after expiration of the warranty only when it is determined to be cost effective.

10. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for beneficiaries;

11. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices;

12. Technology Supports with Remote Features:

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

    b. Medication Reminder System- 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. Requires ability to self-administer medication with reminder and services face-to-face once per month;

    c. Monitoring Device, stand alone or intergraded, include all accessories, components and electronics not otherwise classified. Monitoring Feature device may be interactive audio and video;

    d. Assessment of home, physical and family environment, to determine suitability to meet patient's medical needs;

    e. Purchase of emergency response system; and

    f. Other equipment used to support someone remotely may include but not limited to: electronic motion door sensor devices, door alarms, web-cams, telephones with modifications (large buttons, flashing lights), devices affixed to wheelchair or walker to send alert when fall occurs, text-to-speech software, intercom systems, tablets with features to promote communication or smart device speakers.

13. 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 age 21 and greater not cover under Medicaid state plan:

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

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

i. Documentation of medical necessity on current 90L;

ii. Request for Incontinence Supplies form signed by Physicians, PA or NP;

iii. Prescription from a Physicians, PA or NP; and

iv. Prior Authorization (PA).

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

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

Requirements

All assistive technology items, equipment, accessories, and supplies must meet all applicable manufacture, design and installation requirements.

Must first access and exhaust items furnished under State Plan.

Excludes items that are not of direct medical or remedial benefit to the beneficiary.

Place of Service

AT/SMES equipment, accessories, and supplies are delivered in the beneficiary's home and in the community as applicable. Training is to be provided at the beneficiary's home, at sites where the beneficiary receives waiver services, and/or at other places where the beneficiary engages in activities in their community where the devices will be utilized. Place of service must be in accordance with the beneficiary's POC.

Service Limitations and Exclusions

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 assistive technology/specialized medical equipment and supplies.

To avoid delays in service provisions/implementation, the support coordinator should be familiar with the process for obtaining assistive technology/specialized medical equipment and supplies or durable medical equipment (DME) through the Medicaid State Plan. Service limitations include:

1. Assistive technology devices and specialized equipment and supplies that are of general utility or maintenance and items that are not of direct medical or remedial benefit to the beneficiary are excluded from coverage;

2. Any equipment, device, appliance, or supply that is covered and has been approved under the Medicaid State Plan is excluded from coverage; and

3. For adults over the age of 20 years, specialized wheelchairs, whether motorized, mobile or travel, are not covered as this is a state plan covered item (Durable Medical Equipment (DME));

4. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the beneficiary. All items shall meet applicable standards of manufacture, design, and installation;

5. Incontinence supplies annual maximum cost is $2,500/POC year without exception; and

6. AT/SMES requests with cost exceeding $20,000 should be sent to SORC for review, recommendations and approval.

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, 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;
16. Home security systems, including monthly service; and
17. Whole home gas/electrical generators.

> **NOTE:** A generator should service the immediate living area of the beneficiary that is medically necessary to support life. Whole home gas/electrical generators are not medically necessary for individual medical equipment and supplies.

Overall budget of service and frequency required for an individual in the ROW should allow for 2 waiver services every 30-days. Budget should allow for unanticipated increases in service needs due to changing needs and emergency situations. Exhausting budget funds for assistive technology/specialized medical equipment and supplies is not justification to suspend the 30-day rule.

Reimbursement

Approval of AT/SMES services through ROW is contingent upon the denial of a prior authorization request for the item as a Medicaid State Plan service and demonstration of the direct medical, habilitative, or remedial benefit of the item to the beneficiary.

Items reimbursed in the ROW may be in addition to any medical equipment and supplies furnished under the Medicaid State Plan.

Transportation – Community Access Services

Transportation – Community Access Services are provided to assist the beneficiary who is receiving CLS and Companion Care in becoming involved in their community. This transportation service encourages and fosters the developmental of meaningful relationships in the community that reflect the beneficiary's choice and values.

It provides the beneficiary with a means of access to community activities and resources. The goal is to increase the beneficiary's independence, productivity, and community inclusion and to support self-directed employees benefits as outlined in the beneficiary's POC.

Transportation – Community Access Services provide the beneficiary with a means of access to community activities, community services, and community resources as outlined in the beneficiary's POC.

Place of Service

Transportation – Community Access Services are delivered from the beneficiary's home to the community and back to the beneficiary's home.

Service Units and Limitations

1. Service unit is "one-way," limited to no more than three round trips per day with an annual limit of 264 "one-way" units;

2. All trips have to be in accordance with and included in the POC;

3. The beneficiary must be present for the service to be billed;

4. All trips must be clustered together for geographic efficiency;

5. Greater than three trips per day require approval from the Department or its designee;

6. The beneficiary is to utilize free transportation provided by family, neighbors, friends, and community agencies that can provide transportation into the community are to do so without charge;

7. The beneficiary should access public transportation or the most cost-effective method of transport prior to accessing Transportation-Community Access;

8. Transportation-Community Access Services shall not replace transportation services to medically necessary services under the Medicaid State Plan or transportation services provided as a means to get to and from school;

9. Transportation-Community Access services are not to be used to transport the beneficiary to any day habilitation, pre-vocational, or supported employment services;

10. Transportation-Community Access services may not be provided/billed at the same time on the same day as CLS;

11. Transportation-Community Access are not available to beneficiaries receiving Shared Living Services or Host Home Services; and

12. A Provider is limited to providing services to three beneficiaries.

Service Exclusions

Transportation-Community Access services shall not replace the following services:

1. Transportation services to medically necessary services under the State Plan;

2. Transportation services provided as a means to get to and from school; and

3. Transportation services for Day Habilitation, Prevocational Services, or Supported Employment Services.

Transportation-Community Access is not available to beneficiaries receiving the following services:

1. Shared Living services;

2. Host Home; or

3. Companion Care.

Transportation-Community Access services may not be billed for the same day at the same time as CLS.

Professional Services

Professional services are direct services to beneficiaries based on the beneficiary's need that assist the beneficiary, unpaid caregivers, and/or paid caregivers in carrying out the beneficiary's approved POC and that are necessary to improve the beneficiary's independence and inclusion in their community.

Available professional services include:

1. Occupational Therapy;
2. Physical Therapy;
3. Speech Therapy;
4. Nutrition/Dietary;
5. Social Work; and
6. Psychology.

All services are to be included in the beneficiary's POC. The specific type of professional service delivered must be the area of specialty and licensing held by the professional. Service intensity, frequency, and duration may be short-term, intermittent, or long-term and is determined by individual need.

Beneficiaries under the age of 21 years are to access professional services through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program prior to accessing professional services through ROW.

Professional services may only be furnished and reimbursed through ROW when the services are not covered under the Medicaid State Plan including services available through the beneficiary's Medicaid Managed Care Organization.

The professional service can include:

1. Assessments and/or re-assessments specific to the area of specialty with the goal of identifying status and developing recommendations, treatment, and follow-up;
2. Information to the beneficiary, family, and caregivers, along with other support team members, to assist in planning, developing, and implementing the beneficiary's POC;

3. Training to the beneficiary, family, and caregivers with the goal of skill acquisition and proficiency;

4. Necessary therapy to the beneficiary as indicated in the POC;

5. Consultative services and recommendations as the need arises;

6. Training and counseling services for natural supports and caregivers in a home setting with the goal of developing and maintaining healthy, stable relationships by providing:

   a. Emphasis on the acquisition of coping skills by building upon family strengths; and

   b. Services intended to maximize the emotional and social adjustment and well-being of the individual, family, and caregiver.

7. Providing nutritional services, including dietary evaluation and consultation with individuals or their care provider, which are intended to maximize the individual's nutritional health;

8. Providing therapy to the beneficiary necessary to the development of critical skills as indicated in the POC;

9. Training or therapy to a beneficiary and/or 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;

10. Assistance in increasing independence, participation, and productivity in the beneficiary's home, work, and/or community environments;

    NOTE: Psychologists and social workers will provide supports and services consistent with person-centered practices.

11. Intervening in a crisis situation with the goal of stabilizing and addressing issues related to the cause(s) of the crisis activities may include:

    a. Development of support plan(s);

    b. Training;

    c. Documentation strategies;

d. Counseling;

e. On-call supports;

f. Back-up crisis supports;

g. On-going monitoring; and

h. Intervention.

12. Providers of professional services must maintain adequate documentation to support service delivery and compliance with the approved POC and provide said documentation upon the LDH's request.

Service Units and Limitations

1. Service unit is 15 minutes; and

2. The beneficiary must be present for professional services to be billed.

Services Exclusions

1. Private Insurance must be billed and exhausted prior to accessing waiver funds;

2. Professional services may only be furnished and reimbursed through ROW when the services are medically necessary, or have habilitative or remedial benefit to the beneficiary;

3. Children must access and exhaust services through EPSDT prior to accessing waiver funds; and

4. The following activities are not reimbursable:

   a. Friendly visiting or attending meetings;

   b. Time spent on paperwork or travel;

   c. Time spent writing reports and program motes;

   d. Time spent on the billing of services; and

   e. Other non-medical reimbursable activities.

Nursing Services

Nursing services are medically necessary services that are ordered by a physician and are provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse within the scope of the state's Nurse Practice Act. Nursing services must be provided by a licensed, enrolled home health agency and requires an individual nursing service plan. Nursing services must be in the beneficiary's POC. Nursing services provided in the ROW are an extension of nursing services provided through the Home Health Program covered under the Medicaid State Plan.

Nursing services may include assessments and health related training/education for beneficiaries and caregivers. Nursing services address the healthcare needs of the beneficiary and may include both prevention and primary care activities.

Nursing services must be included in the beneficiary's POC and must have the following:

1. Physician's order;
2. Physician's letter of medical necessity;
3. Form 90-L;
4. Form 485;
5. Individual nursing service plan;
6. Summary of medical history; and
7. Skilled nursing checklist.

The beneficiary's nurse must submit updates every sixty (60) days and must include any changes to the beneficiary's needs and/or any physician's orders.

Consultations include assessments, health related training/education for beneficiary and the beneficiary's caregivers, and healthcare needs related to prevention and primary care activities.

Service Units and Limitations

1. Service unit is 15 minutes;
2. Assessment services are offered on an individual basis only and must be performed by a Registered Nurse;

3. Health related training/education service is the only nursing service which can be provided to more than one beneficiary simultaneously. In this instance, the cost of the service is allocated equally among all beneficiaries receiving the health-related training/education;

4. Nursing Services will not be reimbursed when the beneficiary is in a hospital or other institutional setting;

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

6. The following activities are not reimbursable:

    a. Friendly visiting or attending meetings;

    b. Time spent on paperwork or travel;

    c. Time spent writing reports and program motes;

    d. Time spent on the billing of services; and

    e. Other non-medical reimbursable activities.

Services Requirements

1. Nursing services are secondary to EPSDT services for beneficiaries under the age of 21 years;

2. Beneficiaries under the age of 21 years have access to nursing services (home health and extended care) under the Medicaid State Plan; and

3. Adults have access only to Home Health nursing services under the Medicaid State Plan. Beneficiaries must access and exhaust all available Medicaid State Plan services prior to accessing ROW Nursing services.

Place of Service

Services can be provided in the beneficiary's home, in a vocational/employment setting, or in the community.

Supported Employment

Supported employment services consist of intensive, ongoing supports and services necessary for beneficiaries to achieve the desired outcome of employment in a community setting in the state of Louisiana where a majority of the persons employed are without disabilities. Beneficiaries utilizing these services may need long-term supports for the life of their employment due the nature of their disability, and natural supports may not meet this need.

Services are provided to beneficiaries who are not served by Louisiana Rehabilitation Services or through a local education agency under the Individuals with Disabilities Education Act and who need more intense, long-term monitoring. The beneficiary usually cannot be competitively employed because supports cannot be successfully reduced due to the nature of the beneficiary's disability, and natural supports would not meet this need.

Supported employment services provide supports in the following areas:

1. Individual job placement, group employment, or self-employment;

2. Job assessment, discovery, and development; and

3. Initial job support and job retention.

When Supported Employment services are provided at a work site where a majority of the persons employed are without disabilities, payment is made only for the adaptations, supervision, and training required by the beneficiary as a result of their disabilities, but payment will not be made for the supervisory activities rendered as a normal part of the business setting.

Supported Employment Services are also available to those beneficiaries who are self-employed. Funds for self-employment may not be used to defray any expenses associated with setting up or operating a business.

Supported employment services may be furnished by a coworker or other job-site personnel under the following circumstances:

1. The services furnished are not part of the normal duties of the coworker or other job-site personnel; and

2. These individuals meet the pertinent qualifications for the providers of service.

Initial Job Support and Retention

Support provided to the beneficiary on or off the job site by provider staff consisting of one or more of the following activities:

1. On-the-job support that ensures the beneficiary is able to obtain the necessary skills needed for the job and meet the employer's expectation(s);

2. Personal care assistance with activities of daily living (as needed); and

3. Travel training for the purpose of teaching the beneficiary how to use transportation services.

Transportation

The provider is responsible for all transportation to all work sites related to the provision of services in group employment. Transportation to and from the service site is offered and billable as a component of the Supported Employment Service.

1. Transportation is payable only when a supported employment service is provided on the same day; and

2. Time spent in transportation to and from the program shall not be included in the total number of Supported Employment service hours provided per day.

Service Units and Limitations

Beneficiary may receive more than one type of vocational /habilitation service per day as long as the billing criteria is followed and as long as the requirements for the minimum time spent on a site are adhered to.

Services must be billed in 15 minute units.

The required minimum number of service hours per day per beneficiary are as follows:

1. Individual Supported employment services – 15 minute units One on One shall be billed in quarterly hour units and shall be based on the person centered plan and the beneficiary's ROW budget;

2. Services that assist a beneficiary to develop and operate a Micro-enterprise – 15 minute units;

3. One-on-one services shall be billed in quarterly hour units and shall be based on the person centered plan and the beneficiary's ROW budget;

4. Group employment services shall be billed in quarterly hour units of service up to 8 hours per day and shall be based on the person centered plan and the beneficiary's ROW budget; and

5. Individual job follow-along services may be delivered virtually.

Services Exclusion

1. Beneficiaries receiving individual supported employment services may also receive prevocational or day habilitation services. However, these services cannot be provided during the same service hours;

2. Beneficiaries receiving group supported employment services may also receive prevocational or day habilitation services. However, these services cannot be provided in the same service day;

3. Payment will only be made for the adaptations, supervision, and training required by individuals receiving waiver services and will not include payment for the supervisory activities rendered as a normal part of the business setting;

4. Supported employment cannot be billed for the same time as any other ROW services except for Community Life Engagement Development, Companion Care, and MIHC;

5. Time spent in transportation to and from the program shall not be included in the total number of services hours provided per day;

6. Travel training for the purpose of teaching the beneficiary how to use transportation services may be included in determining the total service numbers hours provided per day, but only for the period of time specified in the POC;

7. Transportation is payable only when a supported employment service provided on the same day;

8. All virtual Supported Employment services must be approved by the LGE or the OCDD State Office; and

9. Supported Employment services are not available to individuals who are eligible to participate in services that are available from programs funded under section 110 of the Rehabilitation Act of 1973 or sections 602 (16) or (17) of the Individuals with Disabilities Education Act [20 U.S.C. 1401 (26) and (29)] and those covered under the state plan, if applicable.

Reimbursement

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 the Louisiana Services Reporting System (LaSRS®) or another EVV system approved by BHSF and OCDD.

Prevocational Services

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

Prevocational services are the overarching services and may be delivered in a combination of these two service types:

1. Onsite Prevocational Services, also referred to as Onsite Community Career Planning (CP);

2. Community CP in small groups; and

3. Prevocational Services may be delivered virtually.

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

Transportation

The provider is responsible for all transportation to between Prevocational sites.

1. Transportation may be provided between the beneficiary's residence, or other location as agreed upon by the beneficiary or authorized representative, and the prevocational site; and

2. The beneficiary's transportation needs shall be documented in the POC.

Under no circumstances can a provider charge a beneficiary, their responsible representative(s), family members or other support team members a separate transportation fee.

Service Units and Limitations

Services shall be based on the person centered plan and the beneficiary's ROW budget. Services are delivered in a 15-minute unit of service for up to 8 hours per day, one or more days per week. The 15-minute unit of services must be spent at the service site by the beneficiary (See Appendix E for Rate and Billing Code information.) Any time less than 15 minutes of service is not billable or payable and no rounding up of units of service is allowed.

Beneficiary may receive more than one type of vocational/habilitation service per day provided the billing criteria and the requirements for the minimum time spent on site are met.

Billing for multiple vocational/habilitative services at the same time is prohibited.

Services Exclusions

Prevocational services cannot be billed at the same time on the same day as other ROW services except for Community Life Engagement Development, Companion Care, or MIHC.

Prevocational services may otherwise be billed at the same time on the same day as Professional services when there are direct contacts needed in the development of a support plan.

Transportation is only provided on the day that a Prevocational service is provided. Transportation is part of the service except for Virtual Prevocational services and:

1. Time spent in transportation between the beneficiary's residence/location and the Prevocational site is not to be included in the total number of Prevocational services hours per day, except when the transportation is for the purpose of travel training;

2. Travel training must be included in the beneficiary's POC;

3. During travel training, providers must not also bill for the transportation component as this is included in the rate for the number of service hours provided;

4. Transportation-community access services shall not be used for transportation to or from any prevocational services;

5. Transportation services (including wheelchair) are offered & billable as a component of Prevocational Services; and

6. Transportation is billed as a separate services per day, typically from the home to the Prevocational Site.

Beneficiaries receiving prevocational services may also receive day habilitation or individualized supported employment services, but these services cannot be provided during the same time period or total more than 5 hours per day combined.

All virtual Prevocational services must be approved by the Local Governing Entity or the OCDD State Office and delivered as outlined in the OCDD Policy and Procedures manual.

Reimbursement

The use of the EVV system is mandatory for all Prevocational services. The EVV system requires the electronic check in/out in the Louisiana Services Reporting System (LaSRS®) or another EVV system approved by BHSF and OCDD.

Day Habilitation Services

Day Habilitation Services assist the beneficiary to gain desired community living experience, including the acquisition, retention, or improvement in self-help, socialization, and adaptive skills, and/or to provide the beneficiary an opportunity to contribute to his or her community.

These services shall be coordinated with any physical, occupational, or speech therapies identified in the individualized POC.

Day Habilitation Services may include assistance with personal care or with activities of daily living, but such assistance should not be the primary activity.

Day Habilitation Services may serve to reinforce skills or lessons taught in other settings.

Volunteer activities may be a part of this service and should follow the state guidelines for volunteering.

Day Habilitation is the overarching service and may be delivered in a combination of these two service types:

1. Onsite Day Habilitation;

2. Community Life Engagement; and

3. Day Habilitation Services may be delivered virtually and are included in the POC.

Day Habilitation Services are provided on a regularly scheduled basis for one or more days per week in a variety of community settings that are separate from the beneficiary's private residence, with the exception of virtual day habilitation.

Day Habilitation Services should not be limited to a fixed site facility.

Activities and environments are designed to foster personal choice in developing the beneficiary's meaningful day including community activities alongside people who do not receive Home and Community Based Services.

Place of Service

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

Transportation

The Day Habilitation provider is responsible for all transportation between day habilitation sites and while providing Community Life Engagement Services in the community.

1. Transportation can only be billed on the day that an in-person day habilitation service is provided; and

2. Transportation is not a part of the service for Virtual Day Habilitation.

NOTE: Under no circumstances can a provider charge a beneficiary, their responsible representative(s), family members or other support team members a separate transportation fee.

Service Units and Limitations

Day Habilitation Services shall be furnished on a regularly scheduled basis for up to 8 hours per day, one or more days per week:

1. Services are based on a 15-minute unit of service and on time spent at the service site and away from the services site, individually or with a group, by the beneficiary;

2. Any time less than 15 minutes of service is not billable or payable. No rounding up of units is allowed;

3. All virtual Day Habilitation Services must be approved by the LGE or the OCDD State Office and delivered as outlined in the OCDD Policy and Procedures manual; and

4. Day Habilitation may not provide for the payment of services that are vocational in nature – for example, the primary purpose of producing goods or performing services.

Beneficiaries receiving Day Habilitation Services may also receive Prevocational and/or Individual Supported Employment Services on the same day, but these services cannot be provided during the same time period or total more than 8 hours per day combined.

Service Exclusions

1. Time spent in transportation between the beneficiaries' residence/location and the day habilitation site is not to be included in the total number of day habilitation services hours per day, except when the transportation is for the purpose of travel training;

2. Travel training for the purpose of teaching the beneficiary to use transportation services may be included in determining the total number of service hours provided per day. Travel training must be included in the beneficiaries POC;

3. Transportation-community access will not be used to transport ROW beneficiaries to any day habilitation services;

4. Day Habilitation Services cannot be billed for at the same time on the same day as:

    a. CLS;

    b. Professional services except when there are direct contacts needed in the development of a support plan;

    c. Respite-Out of Home;

    d. Adult Day Health Care;

    e. Monitored in Home Care Giving (MIHC);

f. Prevocational Services; and

g. Supported Employment.

5. Day Habilitation Services can be billed at the same time on the same day as Community Life Engagement Development, Companion Care, and MIHC.

Reimbursement

The use of the EVV system is mandatory for Day Habilitation Services. The EVV system requires the electronic check in/out in the Louisiana Services Reporting System (LaSRS®) or another EVV system approved by BHSF and OCDD. Day Habilitation transportation is exempt from this mandatory requirement.

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

This should include church involvement, civic involvement, volunteering opportunities, as well as recreational activities.

CLED activities should be integrated with the community and not segregated groups.

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

Transportation

Transportation cost is included in the rate paid to the provider.

Service Units and Limitations

This service can be billed at the same time the beneficiary is receiving a day or employment service. The beneficiary may or may not be present.

15- Minute unit increments

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

Services shall not exceed the number of units as defined in the beneficiaries Plan of Care and must have a prior authorization.

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;
2. Living alone or living with someone else;
3. Accommodations needed;
4. Other important preferences; and
5. 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.

6. 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.

7. 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).

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

9. 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 stabilization service provider plan, and in POC renewal and updates, as needed;

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

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

a. The 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), housing stabilization services will provide supports to retain housing or locate and secure housing to continue community-based supports, including locating new housing, sources of income, etc.

Service Units and Limitations

Services must be billed in 15 minute units.

This service is only available to beneficiaries upon referral from the support coordinator, and is not duplicative of other waiver services, including support coordination. Beneficiaries must be residing in a State of Louisiana Permanent Supportive Housing unit; or linked for the State of Louisiana Permanent Supportive Housing selection process.

Beneficiaries are limited to receiving no more than 165 combined units of Housing Stabilization Transition and Housing Stabilization service. This limit on combined units can only be exceeded with written approval from OCDD.

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.

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 office 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.

Adult Day Health Care Services

ADHC services are furnished as specified in the POC at an ADHC center, in a licensed non-institutional, community-based setting encompassing both health/medical and social services needed to ensure the optimal functioning of the beneficiary.

Adult Day Health Care (ADHC) services include those core service requirements identified in the ADHC licensing standards (LAC 48: I.4243), in addition to the following:

1. Medical care management;

2. Transportation between the beneficiary's place of residence and the ADHC (if the beneficiary is accompanied by the ADHC staff) in accordance with licensing standards;

3. Assistance with activities of daily living;

4. Health and nutrition counseling;

5. An individualized exercise program;

6. An individualized goal-directed recreation program;

7. Health education classes;

8. Individualized health/nursing services; and

9. Meals. Meals shall not constitute a full nutritional regimen (3 meals per day), but shall include a minimum of two snacks and a hot, nutritious lunch per day.

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

Nurses shall be involved in the beneficiary's service delivery as specified in the POC or as needed. Each beneficiary has a POC from which the ADHC shall develop an individualized service plan based on the beneficiary's POC. If the individualized service plan calls for certain

health and nursing services, the nurse on staff shall ensure that the services are delivered while the beneficiary is at the ADHC facility.

Nursing services that are provided by licensed nursing professionals include the following individualized health services:

1. Monitoring vital signs appropriate to the diagnosis and medication regimen of each beneficiary no less frequently than monthly;

2. Administering medications and treatments in accordance with physicians' orders;

3. Developing and monitoring beneficiaries' medication administration plans (self-administration and staff administered) of medications while the beneficiary is at the ADHC center; and

4. Serving as a liaison between the beneficiary and medical resources including the treating physician.

NOTE: All nursing services shall be provided in accordance with professional practice standards and all other requirements identified in the ADHC licensing rules.

Transportation

Transportation services are provided between the beneficiary's place of residence and the ADHC center at the beginning and end of the program day. The following criteria applies:

1. The cost of transportation is included in the rate paid to ADHC centers;

2. The beneficiary and their family may choose to transport the beneficiary to the ADHC center. Transportation provided by the beneficiary's family is not a reimbursable service; and

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

Service Units and Limitations

The following service limitations apply:

1. Services must be billed in 15 minute units;

2. ADHC services shall be provided no more than 10 hours per day and no more than 50 hours per week (exclusive of transportation time to and from the ADHC center, as specified in the beneficiary's POC); and

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

Service Exclusions

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

1. The following services are not available to ADHC beneficiaries:

    a. Monitored in-Home Caregiving (MIHC).

Monitored In-Home Caregiving Services

Monitored in-Home Caregiving (MIHC) are services are provided to a beneficiary living in a private home with a principal caregiver. The principal caregiver shall be contracted by the licensed HCBS provider having a MIHC service module.

The principal caregiver shall reside with the beneficiary. Professional staff employed by the HCBS provider shall provide oversight, support, and monitoring of the principal caregiver, service delivery, and beneficiary outcomes through on-site visits, training, and daily web-based electronic information exchange.

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

Monitored In-Home Caregiving providers must employ professional staff, including a registered nurse and a care manager, to support principal caregivers to perform the direct care activities performed in the home. The provider agency must:

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

2. Pay per diem stipends to caregivers;

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

4. Make such notes available to support coordinators and the state, upon request.

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 (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 POC, and to provide the same supervision or assistance as would be rendered in the home; and

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

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

Service Limitations

LDH will reimburse for Monitored In-Home Caregiving based on a two tiered model which is designed to address the beneficiary's acuity. The following service limitations 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 ADL or IADL assistance;

2. The provision of MIHC services outside of the borders of the state (e.g., overnight excursions, vacation, etc.) is prohibited without written approval by OCDD or its designee;

3. Individual receiving Hospice services may receive Monitored in Home Caregiving services in the ROW as long as services are not related to terminal illness or services are not duplicative of Hospice POC;

4. Professional staff (Care Manager) employed by the HCBS provider shall determine if a beneficiary is receiving Hospice Services and must ensure that services in the waiver POC are not duplicative of services in Hospice POC. If duplication of services is imminent, the individual may not elect MIHC services;

5. If hospice services terminal diagnosis is related to Developmental Disability diagnosis the individual may elect to terminate or remain in hospices services as this is a duplication of Medicaid services;

6. If Professional staff determine there is not duplication of services, then the care coordinator may proceed with the (MIHC) POC coordinated with the hospice provider; and

7. OCDD Waiver Support Coordinator must coordinate all services with Hospice Provider and MIHC Care Manager.

Services Exclusions

Beneficiaries electing monitored in-home caregiving are not eligible to receive the following ROW services during the period of time that the beneficiaries are receiving Monitored In-Home Caregiving services:

1. CLS;

2. Companion Care Supports;

3. Host Home;

4. Shared Living Supports;

5. ADHC; or

6. Skilled Nursing.

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 (FMS)

Financial Management Services (FMS) are provided by a Medicaid enrolled Fiscal Employer Agency.

The Fiscal Employer Agency (FEA) is the fiscal agent that assures financial accountability for self-direction services.

Refer to the Fiscal/Employer Agent (F/EA) Manual for additional information at

https://www.lamedicaid.com/provweb1/providermanuals/manuals/FEA/FEA.pdf