

Subpart 11. New Opportunities Waiver

Chapter 137. General Provisions

§13701. Introduction

A. The new opportunities waiver (NOW), hereafter referred to as NOW, is designed to enhance the long-term services and supports available to individuals with developmental disabilities, who would otherwise require an intermediate care facility for persons with developmental disabilities (ICF-DD) level of care. The mission of NOW is to utilize the principle of self-determination and supplement the family and/or community supports that are available to maintain the individual in the community. In keeping with the principles of self-determination, NOW includes a self-direction service delivery option. This allows for greater flexibility in hiring, training, and general service delivery issues. NOW replaced the mentally retarded/

developmentally disabled (MR/DD) waiver after participants of that waiver were transitioned into NOW.

B. All NOW services are accessed through the case management agency of the participant's choice. All services must be prior authorized and delivered in accordance with the approved plan of care (POC). The POC shall be developed using a person-centered process coordinated by the individual's case manager.

C. Providers must maintain adequate documentation to support service delivery and compliance with the approved plan of care and provide said documentation at the request of the department.

D. In order for the NOW provider to bill for services, the participant and the direct service provider, professional or other practitioner rendering service must be present at the time the service is rendered. The service must be documented in service notes describing the service rendered and progress towards the participant's personal outcomes and POC.

E. Only the following NOW services shall be provided for or billed for the same hours on the same day as any other NOW service:

1. substitute family care;
2. supported living; and
3. skilled nursing services. Skilled nursing services may be provided with:
 - a. substitute family care;
 - b. supported living;
 - c. day habilitation;
 - d. supported employment (all three modules); and/or
 - e. employment-related training.

F. The average participant expenditures for all waiver services shall not exceed the average Medicaid expenditures for ICF-DD services.

G. Providers shall follow the regulations and requirements as specified in the NOW provider manual.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1201 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1647 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:68 (January 2014).

§13703. Participant Qualifications and Admissions Criteria

A. In order to qualify for NOW, an individual must be three years of age or older, offered a waiver opportunity (slot) and meet all of the following criteria:

1. have a developmental disability as specified in R.S. 28:451.2;
2. be on the developmental disabilities (DD) request for services registry (RFSR), unless otherwise specified through programmatic allocation in §13707;
3. meet the financial eligibility requirements for the Medicaid Program;
4. meet the requirements for an ICF-DD level of care which requires active treatment of a developmental disability under the supervision of a qualified developmental disability professional;
5. have assurance that health and welfare of the individual can be maintained in the community with the provision of NOW services;
6. have justification, as documentation in the approved plan of care, that NOW services are appropriate, cost effective and represent the least restrictive environment for the individual;
7. be a resident of Louisiana; and
8. be a citizen of the United States or a qualified alien.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1201 (June 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:96 (January 2014).

§13705. Denial of Admission or Discharge Criteria

A. Individuals shall be denied admission to or discharged from the NOW if one of the following criteria is met:

1. the individual does not meet the financial eligibility requirements for the Medicaid Program;
2. the individual does not meet the requirement for an ICF-DD level of care;
3. the individual is incarcerated or placed under the jurisdiction of penal authorities, courts or state juvenile authorities;
4. the individual resides in another state or has a change of residence to another state;
5. the participant is admitted to an ICF-DD facility or nursing facility with the intent to stay and not to return to waiver services. The waiver participant may return to waiver services when documentation is received from the treating physician that the admission is temporary and shall not exceed 90 days. The participant will be discharged from the waiver on the ninety-first day if the participant is still in the ICF-DD or nursing facility;
6. the health and welfare of the participant cannot be assured through the provision of NOW services within the participant's approved plan of care;
7. the individual fails to cooperate in the eligibility determination/re-determination process and in the development or implementation of the approved POC; and/or
8. continuity of services is interrupted as a result of the individual not receiving a NOW service during a period of 30 or more consecutive days. This does not include

interruptions in NOW services because of hospitalization, institutionalization (such as ICFs-DD or nursing facilities), or non-routine lapses in services where the family agrees to provide all needed or paid natural supports. There must be documentation from the treating physician that this interruption will not exceed 90 days. During this 90-day period, the Office for Citizens with Developmental Disabilities (OCDD) will not authorize payment for NOW services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1202 (June 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities LR 40:69 (January 2014).

§13707. Programmatic Allocation of Waiver Opportunities

A. The request for services registry, hereafter referred to as “the registry,” shall be used to evaluate individuals for waiver eligibility and to fill all waiver opportunities for persons with developmental disabilities. The next individual on the registry shall be notified in writing that a waiver opportunity is available and that he/she is next in line to be evaluated for a possible waiver assignment. The individual shall then choose a case management agency that will assist in the gathering of the documents needed for both the financial eligibility and medical certification process for level of care determination. If the individual is determined to be ineligible, either financially or medically, that individual shall be notified in writing. The next person on the registry shall be notified as stated above and the process continues until an eligible person is assigned the waiver opportunity. A waiver opportunity shall be assigned to an individual when eligibility is established and the individual is certified. By accepting a waiver opportunity, the person’s name shall be removed from the registry.

B. Right of Refusal. A person may be designated inactive on the registry upon written request to OCDD. When the individual determines that he/she is ready to begin the waiver evaluation process, he/she shall request, in writing, that his/her name be removed from inactive status. His/her original protected request date will be reinstated. In addition, persons who left a publicly-operated facility after July 1, 1996 and who would have received a waiver opportunity, but chose another option at the time of discharge, may request access to a waiver opportunity through OCDD or its designated agent. OCDD will verify that the individual meets the criteria for this option and provide access to the next available waiver opportunity based on his/her date of discharge from the publicly-operated facility. That will become his/her protected date.

C. Utilizing these procedures, waiver opportunities shall be allocated to the targeted groups cited as follows.

1. A minimum of 90 waiver opportunities shall be available for allocation to foster children in the custody of the Department of Children and Family Services (DCFS),

Child Welfare Division or its successor, who successfully complete the financial and medical certification eligibility processes and are certified for the waiver. DCFS Child Welfare or its successor is the guardian for children who have been placed in DCFS custody by court order. DCFS or its successor shall be responsible for assisting the individual in gathering the documents needed in the eligibility determination process, preparing the plan of care, and submitting the plan of care document to OCDD.

2. A minimum of 160 waiver opportunities shall be available for people living at Pinecrest Supports and Services Center (formerly known as Pinecrest Development Center), or its alternates at private ICFs-DD, who have chosen to receive community-based waiver services, have successfully completed the financial eligibility and medical certification processes, and are certified for the waiver. For the purposes of assigning these waiver opportunities, an alternate is defined as a person who lives in a private ICF-DD, chooses to apply for waiver participation, is eligible for the waiver, and vacates a bed in the private ICF-DD for an individual being discharged from a publicly-operated facility. A person living at Pinecrest shall have the option to select a private ICF-DD placement in the area of his/her choice in order to designate the individual being discharged from the private ICF-DD as his/her alternate. The bed being vacated in the private ICF-DD must be reserved for 14 days for the placement of a person being discharged from a publicly-operated facility. The person’s discharge from a publicly-operated facility and his/her subsequent placement in a private ICF-DD is to occur as close as possible to the actual discharge of the alternate from the private ICF-DD and is not to exceed 14 days from the date of the alternate’s discharge and certification for the waiver. The bed may be held vacant beyond the 14 days with the concurrence of the private ICF-DD provider.

3. Except for those waiver opportunities addressed in Paragraphs C.1, 2, 6 and 7 of this Section, waiver opportunities vacated during the waiver year shall be made available to persons residing in or leaving any publicly-operated ICF-DD at the time the facility is transferred to any private ICF-DD under a cooperative endeavor agreement with OCDD, or their alternates.

4. A waiver opportunity will be reserved for persons who choose to transition from a publicly-operated facility to community-based waiver services. The reservation of a waiver opportunity shall not exceed 120 days. However, justification to exceed this 120-day reservation period may be granted as needed.

5. Waiver opportunities not utilized by persons living in public ICFs-DD or their alternates shall be divided between:

- a. the next individual on the registry who is living in either a nursing facility or private ICF-DD; and
- b. the next individual on the registry who is residing in the community.

6. Ten waiver opportunities shall be used for qualifying persons with developmental disabilities who receive services from the Developmental Neuropsychiatric Program (DNP). This is a project between OCDD and the Office of Behavioral Health in the development of coordinated wrap-around services for individuals who choose to participate in the waiver and meet the financial and medical eligibility requirements for the waiver.

7. Two hundred and eighty-one waiver opportunities shall be used for qualifying individuals with developmental disabilities who require emergency waiver services. In the event that a waiver opportunity is vacated, the opportunity will be returned to the emergency pool for support planning based on the process for prioritization. Once the 281 waiver opportunities are filled, then supports and services based on the priority determination system will be identified and addressed through other resources currently available for individuals with developmental disabilities.

8. Funded waiver opportunities not addressed above shall be available for allocation to the next individual on the registry who successfully completes the financial eligibility and medical certification process and is certified for the waiver.

D. The Office for Citizens with Developmental Disabilities has the responsibility to monitor the utilization of NOW waiver opportunities. At the discretion of the OCDD, specifically allocated waiver opportunities may be reallocated to better meet the needs of citizens with developmental disabilities in the State of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 31:2900 (November 2005), amended LR 33:2440 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 37:3526 (December 2011), LR 40:70 (January 2014).

Chapter 139. Covered Services

§13901. Individualized and Family Support Services

A. Individual and family support (IFS) services are direct support and assistance services provided in the home or the community that allow the participant to achieve and/or maintain increased independence, productivity, enhanced family functioning and inclusion in the community or for the relief of the primary caregiver. Transportation is included in the reimbursement for these services. Reimbursement for these services includes the development of a service plan for the provision of these services, based on the approved POC.

1. Individual and family support day (IFS-D) services will be authorized during waking hours for up to 16 hours when natural supports are unavailable in order to provide continuity of services to the participant. Waking hours are the period of time when the participant is awake and not limited to traditional daytime hours.

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

2. Individual and family support-night (IFS-N) service is direct support and assistance provided during the participant's sleeping "night" hours. Night hours are considered to be the period of time when the participant is asleep and there is a reduced frequency and intensity of required assistance. IFS-N services are not limited to traditional nighttime hours. The IFS-N worker must be immediately available and in the same residence as the participant to be able to respond to the participant's immediate needs. Documentation of the level of support needed, based on the frequency and intensity of needs, shall be included in the POC with supporting documentation in the provider's services plan. Supporting documentation shall outline the participant's safety, communication, and response methodology planned for and agreed to by the participant and/or his/her authorized representative identified in his/her circle of support. The IFS-N worker is expected to remain awake and alert unless otherwise authorized under the procedures noted below.

a. Participants who are able during sleeping hours to notify direct support workers of his/her need for assistance may choose the option of IFS-N services where staff is not required to remain awake.

b. The participant's support team shall assess the participant's ability to awaken staff. If it is determined that the participant is able to awaken staff and requests that the

IFS-N worker be allowed to sleep, the POC shall reflect the participant's request.

c. Support teams should consider the use of technological devices that would enable the participant to notify/awaken IFS-N staff. (Examples of devices include wireless pagers, alerting devices such as a buzzer, a bell or a monitoring system.) If the method of awakening the IFS-N worker utilizes technological device(s), the service provider will document competency in use of devices by both the participant and IFS-N staff prior to implementation. The support coordinator will require a demonstration of effectiveness of this service no less than quarterly.

d. A review shall include review of log notes indicating instances when IFS-N staff was awakened to attend to the participant. Also included in the review is acknowledgement by the participant that IFS-N staff responded to his/her need for assistance timely and appropriately. Instances when staff did not respond appropriately will immediately be brought to the support team for discontinuation of allowance of the staff to sleep. The service will continue to be provided by awake and alert staff.

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

B. IFS services may be shared by up to three waiver participants who may or may not live together and who have a common direct service provider agency. Waiver participants may share IFS services staff when agreed to by the participants and health and welfare can be assured for each participant. The decision to share staff must be reflected on the POC and based on an individual-by-individual determination. Reimbursement rates are adjusted accordingly. Shared IFS services, hereafter referred to as shared support services, may be either day or night services.

C. IFS (day or night) services include:

1. assisting and prompting with the following activities of daily living (ADL):

- a. personal hygiene;
- b. dressing;
- c. bathing;
- d. grooming;
- e. eating;
- f. toileting;
- g. ambulation or transfers;
- h. other personal care and behavioral support needs;
- i. any medical task which can be delegated;

and

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

- a. housekeeping;
- b. laundry;
- c. cooking;
- d. evacuating the home in emergency situations;
- e. shopping; and
- f. money management;

3. personal support and assistance in participating in community, health, and leisure activities;

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

5. enabling and promoting individualized community supports targeted toward inclusion into meaningful integrated experiences; and

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

D. Exclusions. The following exclusions apply to IFS services.

1. Reimbursement shall not be paid for services furnished by a legally responsible relative. A *legally responsible relative* is defined as the parent of a minor child, foster parent, curator, tutor, legal guardian, or the participant's spouse.

2. IFS-D and IFS-N services shall not include services provided in the IFS-D or IFS-N worker's residence, regardless of the relationship.

3. ISF-D and IFS-N services will not be authorized or provided to the participant while the participant is in a center-based respite facility.

4. Remote assistance serves as a replacement for IFS; therefore, remote assistance and IFS services are not billable during the same time period.

E. Staffing Criteria and Limitations

1. IFS-D or IFS-N services may be provided by a member of the participant's family, provided that the participant does not live in the family member's residence and the family member is not the *legally responsible relative* as defined in §13901.D.1.

2. Family members who provide IFS services must meet the same standards as providers or direct care staff who are unrelated to the participant.

3. An IFS-D or IFS-N worker shall not work more than 16 hours in a 24-hour period unless there is a documented emergency or a time-limited non-routine need

that is documented in the approved POC. An IFS-D or IFS-N shared supports worker shall not work more than 16 hours in a 24-hour period unless there is a documented emergency or a time-limited non-routine need that is documented in the approved POC.

F. Place of Service

1. IFS services shall be provided in the state of Louisiana. IFS services may be performed outside the state for a time-limited period or for emergencies. The provision of services outside of the state must be prior-approved by the department.

2. Provision of IFS services shall not be authorized outside of the United States or the Territories of the United States.

3. The provision of IFS services in licensed congregated settings shall be excluded from coverage.

G. Provider Requirements. Providers must be licensed by the Louisiana Department of Health and Hospitals as a home and community-based services provider and must meet the module specific requirements for the service being provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1202 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:2063 (November 2006), LR 33:1647 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:71 (January 2014).

§13903. Center-Based Respite Care

A. Center-based respite (CBR) care is temporary, short-term care provided to a participant with developmental disabilities who requires support and/or supervision in his/her day-to-day life due to the absence or relief of the primary caregiver. While receiving center-based respite care, the participant's routine is maintained in order to attend school, work or other community activities/outings. The respite center is responsible for providing transportation for community outings, as that is included as part of its reimbursement. Individual and family support services (both day and night) will not be reimbursed while the participant is in a center-based respite facility.

B. Exclusions. The cost of room and board is not included in the reimbursement paid to the respite center.

C. Service Limits. CBR services shall not exceed 720 hours per participant, per POC year.

1. Participants may request approval of hours in excess of 720 hours. The request must be submitted to the OCDD central office with proper justification and documentation for prior approval.

D. Provider Requirements. Providers must be licensed by the Louisiana Department of Health and Hospitals as a home

and community-based services provider and must meet the module specific requirements for the service being provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1203 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1648 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:72 (January 2014).

§13905. Community Integration Development

A. Community integration development (CID) facilitates the development of opportunities to assist participants in becoming involved in the community through the creation of natural supports. The purpose of CID is to encourage and foster the development of meaningful relationships in the community reflecting the participant's choices and values. Objectives outlined in the plan of care will afford opportunities to increase community inclusion, participation in leisure/recreational activities, and encourage participation in volunteer and civic activities. Reimbursement for this service includes the development of a service plan. To utilize this service, the participant may or may not be present as identified in the approved CID service plan. CID services may be performed by shared staff for up to three waiver participants who have a common direct service provider agency. The shared staff shall be reflected on the POC and based on an individual-by-individual determination. Rates shall be adjusted accordingly.

B. Transportation costs are included in the reimbursement for CID services.

C. Service Limitations. Services shall not exceed 60 hours per participant per POC year which includes the combination of shared and non-shared community integration development.

D. Provider Qualifications. Providers must be licensed by the Louisiana Department of Health and Hospitals as a home and community-based services provider and must meet the module specific requirements for the service being provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1203 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1648 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:72 (January 2014).

§13907. Supported Living

A. Supported living (SL) assists the participant to acquire, improve or maintain those social and adaptive skills necessary to enable a participant to reside in the community

and to participate as independently as possible. SL services include assistance and/or training in the performance of tasks such as personal grooming, housekeeping and money management. Payment for this service includes oversight and administration and the development of service plans for the enhancement of socialization with age-appropriate activities that provide enrichment and may promote wellness. The service plan should include initial, introduction, and exploration for positive outcomes for the participant for community integration development. These services also assist the participant in obtaining financial aid, housing, advocacy and self-advocacy training as appropriate, emergency support, trained staff and assisting the participant in accessing other programs for which he/she qualifies. SL participants must be 18 years or older.

B. Place of Service. Services are provided in the participant's residence and/or in the community. The participant's residence includes his/her apartment or house, provided that he/she does not live in the residence of any legally responsible relative. An exception will be considered when the participant lives in the residence of a spouse or disabled parent, or a parent age 70 or older. Family members who are not *legally responsible relatives* as defined in §13901.D.1, can be SL workers provided they meet the same qualifications as any other SL worker.

C. Exclusions

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

2. SL shall not include the cost of:

- a. meals or the supplies needed for preparation;
- b. room and board;
- c. home maintenance, or upkeep and improvement;
- d. routine care and supervision which could be expected to be provided by a family member; or
- e. activities or supervision for which a payment is made by a source other than Medicaid, e.g., Office for Citizens with Developmental Disabilities, etc.

3. SL services cannot be provided in a substitute family care setting.

D. Service Limit. SL services are limited to one service per day, per POC year, except when the participant is in center-based respite. When a participant living in an SL setting is admitted to a center-based respite facility, the SL provider shall not bill the SL per diem beginning with the date of admission to the center-based respite facility and through the date of discharge from the center-based respite facility.

E. Provider Qualifications. Providers must be licensed by the Louisiana Department of Health and Hospitals as a home and community-based services provider and meet the module specific requirements for the service being provided.

F. Provider Responsibilities

1. Minimum direct services by the SL agency include two documented phone contacts per week and one documented face-to-face contact per month by the SL provider agency in addition to the approved direct support hours. These required contacts must be completed by the SL agency supervisor or a licensed/certified professional qualified in the state of Louisiana who meets requirements as defined by 42 CFR §483.430.

2. The provider must furnish back-up staff that is available on a 24-hour basis.

3. Supported living services shall be coordinated with any services listed in the approved POC, and may serve to reinforce skills or lessons taught in school, therapy or other settings.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1204 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1648 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:73 (January 2014).

§13909. Substitute Family Care

A. Substitute family care (SFC) provides for day programming, transportation, independent living training, community integration, homemaker, chore, attendant care and companion services, and medication oversight (to the extent permitted under state law) to participants residing in a licensed substitute family care home. The service is a stand-alone family living arrangement for participants age 18 and older. The SFC house parents assume the direct responsibility for the participant's physical, social, and emotional well-being and growth, including family ties. There shall be no more than three participants living in a substitute family care setting who are unrelated to the SFC provider. Immediate family members (mother, father, brother and/or sister) cannot be substitute family care parents. Reimbursement for this service includes the development of a service plan based on the approved POC.

B. Service Limits. SFC services are limited to one service per day.

C. Exclusions. The following exclusions apply to SFC services.

1. Remote assistance and surveillance systems may not be used concurrently with SFC services or in the SFC home.

D. Provider Qualifications. Providers must be licensed by the Louisiana Department of Health and Hospitals as a home and community-based services provider and must meet the module specific requirements for the service being provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1204 (June 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:73 (January 2014).

§13911. Day Habilitation

A. Day habilitation is provided in a community-based setting and provides the participant assistance with social and adaptive skills necessary to enable the participant to participate as independently as possible in the community. These services focus on socialization with meaningful age-appropriate activities which provide enrichment and promote wellness, as indicated in the participant's POC.

1. Day habilitation services must be directed by a service plan and provide assistance and/or training in the performance of tasks related to acquiring, maintaining or improving skills including, but not limited to:

- a. personal grooming;
- b. housekeeping;
- c. laundry;
- d. cooking;
- e. shopping; and
- f. money management.

2. Day habilitation services shall be coordinated with any therapy, employment-related training, or supported employment models that the participant may be receiving. The participant does not receive payment for the activities in which he/she are engaged. The participant must be 18 years of age or older in order to receive day habilitation services.

B. Service Limits. Services can be provided one or more hours per day but not to exceed eight hours per day or 8,320 one quarter hour units of service per POC year.

C. Licensing Requirements. Providers must be licensed by the Louisiana Department of Health and Hospitals as a home and community-based services provider and must meet the module specific requirements for the service being provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1204 (June 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:73 (January 2014).

§13913. Supported Employment

A. Supported employment is competitive work in an integrated work setting, or employment in an integrated work setting in which the participants are working toward competitive work that is consistent with the strengths, resources, priorities, interests, and informed choice of

participants for whom competitive employment has not traditionally occurred. The participant must be 18 years of age or older in order to receive supported employment services.

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

C. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed by waiver participants to sustain paid work, including supervision and training and is based on an individualized service plan. Supported employment includes assistance and prompting with:

1. personal hygiene;
 2. dressing;
 3. grooming;
 4. eating;
 5. toileting;
 6. ambulation or transfers;
 7. other personal care and behavioral support needs;
- and
8. any medical task which can be delegated.

D. Supported Employment Models. Reimbursement for supported employment includes an individualized service plan for each model.

1. A one-to-one model of supported employment is a placement strategy in which an employment specialist (job coach) places a person into competitive employment, provides training and support and then gradually reduces time and assistance at the work site. This service is time limited to six to eight weeks in duration.

2. Follow along services are designed for participants who are in supported employment and have been placed in a work site and only require minimum oversight for follow along at the job site. This service is limited to 52 days per POC year.

3. Mobile work crew/enclave is an employment setting in which a group of two or more participants, but fewer than eight perform work in a variety of locations under the supervision of a permanent employment specialist (job coach/supervisor). This service is up to eight hours a day, five days per week.

E. Service Exclusions

1. Services shall not be used in conjunction or simultaneously with any other waiver service, except substitute family care, supported living, and skilled nursing services.

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

3. Services are not available to individuals who are eligible to participate in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act, 20 U.S.C. 1401(16) and (71).

F. Service Limits

1. One-to-one intensive services shall not exceed 1,280 1/4 hour units per POC year. Services shall be limited to eight hours a day, five days a week, for six to eight weeks.

2. Follow along services shall not exceed 52 days per POC year.

3. Mobile crew/enclave services shall not exceed 8,320 one quarter hour units of service per POC year, without additional documentation. This is eight hours per day, five days per week.

G. Licensing Requirements. The provider must possess a valid certificate of compliance as a community rehabilitation provider (CRP) from Louisiana Rehabilitation Services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1205 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:74 (January 2014).

§13915. Transportation for Day Habilitation and Supported Employment Models

A. Transportation provided for the participant to the site of the day habilitation or supported employment model, or between the day habilitation and supported employment model site (if the participant receives services in more than one place) is reimbursable when day habilitation or supported employment model has been provided. Reimbursement may be made for a one-way trip if reason is documented in provider's transportation log. There is a maximum fee per day that can be charged for transportation regardless of the number of trips per day.

B. Licensing Requirements. Providers must be licensed by the Louisiana Department of Health and Hospitals as a home and community-based services provider and meet the module specific requirements for the service being provided. The licensed provider must carry \$1,000,000 liability insurance on the vehicles used in transporting the participants.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1205 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:2064 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:74 (January 2014).

§13917. Employment-Related Training

A. Employment-related training consists of paid employment for participants for whom competitive employment at or above the minimum wage is unlikely, and who need intensive ongoing support to perform in a work setting because of disabilities. Services are aimed at providing participants with opportunities for employment and related training in work environments one to eight hours a day, one to five days a week at a commensurate wage in accordance with United States Department of Labor regulations and guidelines. Employment-related training services include training designed to improve and maintain the participant's capacity to perform productive work and to function adaptively in the work environment. The participant must be 18 years or older in order to receive employment-related training services. Reimbursement for these services includes transportation and requires an individualized service plan.

B. Employment-related training services include, but are not limited to:

1. assistance and prompting in the development of employment related skills. This may include:

- a. assistance with personal hygiene;
- b. dressing;
- c. grooming;
- d. eating;
- e. toileting;
- f. ambulation or transfers;
- g. behavioral support needs; and
- h. any medical task which can be delegated.

2. employment at a commensurate wage at a provider facility for a set or variable number of hours;

3. observation of an employee of an area business in order to obtain information to make an informed choice regarding vocational interest;

4. instruction on how to use equipment;

5. instruction on how to observe basic personal safety skills;

6. assistance in planning appropriate meals for lunch while at work;

7. instruction on basic personal finance skills; and

8. information and counseling to a participant and, as appropriate, his/her family on benefits planning and assistance in the process.

C. Exclusions. The following service exclusions apply to employment-related training.

1. Services are not available to participants who are eligible to participate in programs funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act, 20 U.S.C. 1401(16) and (71).

D. Service Limits. Services shall not exceed eight hours a day, five days a week, and cannot exceed 8,320 one quarter hour units of service per POC year.

E. Licensing Requirements. Providers must be licensed by the Louisiana Department of Health and Hospitals as a home and community-based services provider and must meet the module specific requirements for the service being provided. The provider must also possess a valid certificate of compliance as a community rehabilitation provider (CRP) from Louisiana Rehabilitation Services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1205 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:75 (January 2014).

§13919. Environmental Accessibility Adaptations

A. Environmental accessibility adaptations are physical adaptations to the home or a vehicle that are necessary to ensure the health, welfare, and safety of the participant or that enable him/her to function with greater independence in the home and/or community. Without these services, the participant would require additional supports or institutionalization.

B. Such adaptations may include:

1. installation of ramps and/or grab-bars;
2. widening of doorways;
3. modification of bathroom facilities;

4. installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies for the welfare of the participant; or

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

C. Requirements for Authorization. Items reimbursed through NOW funds shall be supplemental to any adaptations furnished under the Medicaid state plan.

1. Any service covered under the Medicaid state plan shall not be authorized by NOW. The environmental accessibility adaptation(s) must be delivered, installed, operational and reimbursed in the POC year in which it was approved. 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 for prior authorization. Modifications may be applied to rental or leased property with the written approval of the landlord and approval of the human services authority or district. Reimbursement shall not be paid until receipt of written documentation that the job has been completed to the satisfaction of the participant.

2. Upon completion of the work and prior to payment, the provider shall give the participant a certificate of warranty for all labor and installation and all warranty certificates from manufacturers.

3. Excluded are those adaptations or improvements to the residence that are of general utility or maintenance and are not of direct medical or remedial benefit to the participant, including, but not limited to:

- a. air conditioning or heating;
- b. flooring;
- c. roofing, installation or repairs;
- d. smoke and carbon monoxide detectors, sprinklers, fire extinguishers, or hose; or
- e. furniture or appliances.

4. Adaptations which add to the total square footage or add to the total living area under the roof of the residence are excluded from this benefit.

5. Home modification is not intended to cover basic construction cost.

6. Excluded are those vehicle adaptations which are of general utility or for maintenance of the vehicle or repairs to adaptations. Car seats are not considered a vehicle adaptation.

D. Service Limits. There is a cap of \$7,000 per participant for environmental accessibility adaptations. Once a recipient reaches 90 percent or greater of the cap and the account has been dormant for three years, the participant may access another \$7,000. Any additional environmental accessibility expenditures during the dormant period reset the three-year time frame. On a case-by-case basis, with supporting documentation and based on need, a participant may be able to exceed this cap with the prior approval of OCDD central office.

E. Provider Qualifications. The provider must be an enrolled Medicaid provider and comply with applicable state and local laws governing licensure and/or certification.

1. All providers of environmental accessibility adaptations must be registered through the Louisiana State Licensing Board for Contractors as a home improvement

contractor, with the exception of providers of vehicle adaptations.

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1206 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:75 (January 2014).

§13921. Specialized Medical Equipment and Supplies

A. Specialized medical equipment and supplies (SMES) are devices, controls, or appliances which enable the participant to:

- 1. increase his/her ability to perform the activities of daily living;
- 2. ensure safety; or
- 3. perceive, control and communicate with the environment in which he/she lives.

B. The service includes medically necessary durable and nondurable medical equipment not covered under the Medicaid state plan. NOW will not cover non-medically necessary items. All items shall meet applicable standards of manufacture, design and installation. Routine maintenance or repair of specialized medical equipment is funded under this service.

C. All alternate funding sources that are available to the participant shall be pursued before a request for the purchase or lease of specialized equipment and supplies will be considered.

D. Exclusion. Excluded are specialized equipment and supplies that are of general utility or maintenance, but are not of direct medical or remedial benefit to the participant. Refer to the New Opportunities Waiver provider manual for a list of examples.

E. Service Limitations. There is a cap of \$1,000 per participant for specialized equipment and supplies. Once a participant reaches 90 percent or greater of the cap and the account has been dormant for three years, the participant may access another \$1,000. Any additional specialized equipment and supplies expenditures during the dormant period reset the three-year time frame. On a case-by-case basis, with supporting documentation and based on need, a participant may be able to exceed this cap with the prior approval of OCDD central office.

F. Provider Qualifications. All agencies who are vendors of technological equipment and supplies must be enrolled in

the Medicaid Program as a durable medical equipment provider and must meet all applicable vendor standards and requirements for manufacturing, design and installation of technological equipment and supplies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1207 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:75 (January 2014).

up to the age of 21, who participate in NOW must access these services through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Professional services may only be furnished and reimbursed through NOW when the services are not covered under the Medicaid state plan. Professional services must be delivered with the participant present and be provided based on the approved POC and an individualized service plan. Service intensity, frequency and duration will be determined by individual need. Professional services may be utilized to:

1. perform assessments and/or re-assessments and recommendations;
2. provide consultative services and recommendations;
3. provide training or therapy to a participant and/or his/her natural and formal supports necessary to either develop critical skills that may be self-managed by the participant or maintained according to the participant's needs;
4. intervene in and stabilize a crisis situation, behavioral or medical, that could result in the loss of home and community-based services; or
5. provide necessary information to the participant, family, caregivers and/or team to assist in the implementation of plans according to the approved POC.

B. Professional services are limited to the following services.

1. Psychological services are direct services performed by a licensed psychologist, as specified by state law and licensure. These services are for the treatment of a behavioral or mental condition that addresses personal outcomes and goals desired by the participant and his/her team. Services must be reasonable and necessary to preserve and improve or maintain adaptive behaviors or decrease maladaptive behaviors of a person with developmental disabilities. Service intensity, frequency, and duration will be determined by individual need.

2. Social work services are highly specialized direct counseling services furnished by a licensed clinical social worker and designed to meet the unique counseling needs of individuals with development disabilities. Counseling may address areas such as human sexuality, depression, anxiety disorders, and social skills. Services must only address those personnel outcomes and goals listed in the approved POC.

3. Nutritional/Dietary services are medically necessary direct services provided by a licensed registered dietician or licensed nutritionist. Services must be ordered by a physician. Direct services may address health care and nutritional needs related to prevention and primary care activities, treatment and diet. Reimbursement is only available for the direct service performed by a dietitian or nutritionist, and not for the supervision of a dietician or nutritionist performing the hands-on direct service.

C. Service Limits. There shall be a \$2,250 cap per participant per POC year for the combined range of

§13925. Professional Services

A. Professional services are services designed to increase the participant's independence, participation and productivity in the home, work and community. Participants,

professional services in the same day but not at the same time. Additional services may be prior authorized if the participant reaches the cap before the expiration of the plan of care and the participant's health and safety is at risk.

D. **Provider Qualifications.** The provider of professional services must be a Medicaid-enrolled provider. Each professional must possess a current valid Louisiana license to practice in his/her field and have at least one year of experience post licensure in his/her area of expertise.

E. **Non-reimbursable Activities.** The following activities are not reimbursable:

1. friendly visiting, attending meetings;
2. time spent on paperwork or travel;
3. time spent writing reports and progress notes;
4. time spent on the billing of services; and
5. other non-Medicaid reimbursable activities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1207 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1650 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:76 (January 2014).

§13927. Skilled Nursing Services

A. **Skilled nursing services** are medically necessary nursing services ordered by a physician and provided by a licensed registered nurse or a licensed practical nurse. Skilled nursing services shall be provided by a licensed, enrolled home health agency and require an individual nursing service plan. These services must be included in the participant's approved POC. All Medicaid state plan services must be utilized before accessing this service. Participants, up to the age of 21, must access these services as outlined on the POC through the Home Health Program.

B. When there is more than one participant in the home receiving skilled nursing services, services may be shared and payment must be coordinated with the service authorization system and each participant's approved POC. Nursing consultations are offered on an individual basis only.

C. **Provider Qualifications.** The provider must be licensed by the Louisiana Department of Health and Hospitals as a home and community-based services provider and must meet the module specific requirements for the service being provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1208 (June 2004), amended by the Department of Health and Hospitals, Office of the

Secretary, Office for Citizens with Developmental Disabilities, LR 33:1651 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:77 (January 2014).

§13929. One Time Transitional Expenses

A. **One-time transitional expenses** are those allowable expenses incurred by participants who are being transitioned from an ICF-DD to his/her own home or apartment in the community of their choice. *Own home* shall mean the participant's own place of residence and does not include any family members home or substitute family care homes.

B. **Allowable transitional expenses** include:

1. the purchase of essential furnishings such as:

- a. bedroom and living room furniture;
- b. table and chairs;
- c. window blinds;
- d. eating utensils; and
- e. food preparation items;

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

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

4. non-refundable security deposits.

C. **Service Limits.** Set-up expenses are capped at \$3,000 over a participant's lifetime.

D. **Service Exclusion.** Transitional expenses shall not constitute payment for housing, rent, or refundable security deposits.

E. **Provider Qualifications.** This service shall only be provided by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities (OCDD) with coordination of appropriate entities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1208 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1651 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:77 (January 2014).

§13931. Adult Companion Care

A. **Adult companion care** services assist the participant to achieve and/or maintain the outcomes of increased independence, productivity and inclusion in the community. These services are designed for individuals who live independently and can manage his/her own household with limited supports. The companion is a principal care provider who provides services in the participant's home and lives

with the participant as a roommate. Adult companion care services may be furnished through self-direction or through a licensed provider organization as outlined in the participant's POC. This service includes:

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

B. Adult companion care services are arranged by provider organizations that are subject to licensure. The companion is an employee of the provider organization and is responsible for providing limited, daily direct services to the participant.

1. The companion shall be available in accordance with a pre-arranged time schedule and available by telephone for crisis support on short notice.
2. Services may not be provided by a family member who is not the participant's spouse, parent or legal guardian.

C. Provider Responsibilities

1. The provider organization shall develop a written agreement as part of the participant's POC which defines all of the shared responsibilities between the companion and the participant. The written agreement shall include, but is not limited to:

- a. types of support provided by the companion;
- b. activities provided by the companion; and
- c. a typical weekly schedule.

2. Revisions to this agreement must be facilitated by the provider organization and approved by the support team. Revisions may occur at the request of the participant, the companion, the provider or other support team members.

3. The provider organization is responsible for performing the following functions which are included in the daily rate:

- a. arranging the delivery of services and providing emergency services;
- b. making an initial home visit to the participant's home, as well as periodic home visits as required by the department;
- c. contacting the companion a minimum of once per week or as specified in the participant's plan of care; and
- d. providing 24-hour oversight and supervision of the adult companion care services, including back-up for the scheduled and unscheduled absences of the companion.

4. The provider shall facilitate a signed written agreement between the companion and the participant which assures that:

a. the companion's portion of expenses must be at least \$200 per month, but shall not exceed 50 percent of the combined monthly costs which includes rent, utilities and primary telephone expenses; and

b. inclusion of any other expenses must be negotiated between the participant and the companion. These negotiations must be facilitated by the provider and the resulting agreement must be included in the written agreement and in the participant's POC.

D. Companion Responsibilities

1. The companion is responsible for:

- a. participating in, and abiding by, the POC;
- b. maintaining records in accordance with state and provider requirements; and
- c. purchasing his/her own food and personal care items.

E. Service Limits

1. Adult companion care services may be authorized for up to 360 hours per year as documented in the participant's POC.

F. Service Exclusions

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

2. Participants receiving adult companion care services are not eligible for receiving the following services:

- a. supported living;
- b. individual and family support;
- c. substitute family care; or
- d. skilled nursing.

G. Provider Qualifications. Providers must be licensed by the Louisiana Department of Health and Hospitals as a home and community-based services provider and must meet the module specific requirements for the service being provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:77 (January 2014).

§13933. Remote Assistance

A. Remote visual monitoring and on-site audio response system(s) include the provision of oversight and monitoring within the residential setting of adult waiver participants through the off-site electronic surveillance. Also included is the provision of stand-by intervention staff prepared for prompt engagement with the participant and/or immediate deployment to the residential setting.

B. Remote visual monitoring and on-site audio response system may be installed in the participant's home in which

residing adult participant(s), guardian(s), and support team(s) request such surveillance and monitoring in place of on-site staffing.

1. Use of the system may be restricted to certain hours as identified through the POC(s) of the participant(s) involved.

2. The request for the system to be installed must be reviewed and approved by the OCDD assistant secretary or designee prior to installation.

C. Provider Responsibilities

1. To be reimbursed for operating a remote assistance system, a provider must adhere to all applicable policies and procedures.

2. Each remote site will have a written policy and procedure approved by the human services authority or district that defines emergency situations and details how remote and float staff will respond to each. This information must be available to support coordinators and providers serving participants.

3. Emergency response drills must be carried out once per quarter per shift in each home equipped with and capable of utilizing the electronic monitoring service. Documentation of the drills must be available for review upon request by OCDD or its representative.

D. Service Limits

1. Services may be shared by up to four participants who live together.

E. Service Exclusions

1. Remote assistance and surveillance systems which have not received specific approval by the OCDD assistant secretary or designee are excluded.

2. Remote assistance and surveillance systems may not be used concurrently with substitute family care services or in the substitute family care home.

3. Remote assistance is not to be used to monitor direct care staff.

4. Remote assistance serves as a replacement for individual and family support services (IFS); therefore, remote assistance and IFS services are not billable during the same time period.

5. Remote assistance cannot be used in place of direct care staff to monitor minors (participants under the age of 18 years).

6. Remote assistance services may be provided by a member of the participant's family, provided that the participant does not live in the family member's residence and the family member is not the legally responsible relative. A *legally responsible relative* is defined as the parent of a minor child, foster parent, curator, tutor, legal guardian, or the participant's spouse.

F. Provider Requirements. Providers must be licensed by the Louisiana Department of Health and Hospitals as a home

and community-based services provider and must meet the module specific requirements for the service being provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:78 (January 2014).

§13935. Housing Stabilization Transition Service

A. Housing stabilization transition service enables participants who are transitioning into a permanent supportive housing unit, including those transitioning from institutions, to secure their own housing. The service is provided while the participant is in an institution and preparing to exit the institution using the waiver. The service includes the following components:

1. conducting a housing assessment to identify the participant's preferences related to housing (i.e., type, location, living alone or with someone else, accommodations needed, and other important preferences), and his/her needs for support to maintain housing, including:

- a. access to housing;
- b. meeting the terms of a lease;
- c. eviction prevention;
- d. budgeting for housing/living expenses;
- e. obtaining/accessing sources of income necessary for rent;
- f. home management;
- g. establishing credit; and
- h. understanding and meeting the obligations of tenancy as defined in the lease terms;

2. assisting the participant to view and secure housing as needed. This may include arranging or providing transportation. The participant shall be assisted in securing supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings;

3. developing an individualized housing support plan based upon the housing assessment that:

- a. includes short- and long-term measurable goals for each issue;
- b. establishes the participant's approach to meeting the goal; and
- c. identifies where other provider(s) or services may be required to meet the goal;

4. participating in the development of the plan of care and incorporating elements of the housing support plan; and

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

B. This service is only available upon referral from the support coordinator and is not duplicative of other waiver services, including support coordination. It is only available to persons who are residing in a state of Louisiana permanent supportive housing unit or who are linked for the state of Louisiana permanent supportive housing selection process.

C. Participants may not exceed 165 combined units of this service and the housing stabilization service.

1. Exceptions to the 165 unit limit can only be made with written approval from the OCDD.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:78 (January 2014).

§13937. Housing Stabilization Service

A. Housing stabilization service enables waiver participants to maintain their own housing as set forth in the participant'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 to identify the participant's preferences related to housing (i.e., type, location, living alone or with someone else, accommodations needed, and other important preferences), and his/her needs for support to maintain housing, including:

- a. access to housing;
- b. meeting the terms of a lease;
- c. eviction prevention;
- d. budgeting for housing/living expenses;
- e. obtaining/accessing sources of income necessary for rent;
- f. home management;
- g. establishing credit; and
- h. understanding and meeting the obligations of tenancy as defined in the lease terms;

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

3. developing an individualized housing stabilization service provider plan based upon the housing assessment that includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies where other provider(s) or services may be required to meet the goal;

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

5. providing ongoing communication with the landlord or property manager regarding the participant's disability, accommodations needed, and 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 participant's situation or status; and

7. if at any time the participant's housing is placed at risk (e.g., eviction, loss of roommate or income), housing stabilization service will provide supports to retain housing or locate and secure housing to continue community-based supports, including locating new housing, sources of income, etc.

B. This service is only available upon referral from the support coordinator and the service is not duplicative of other waiver services including support coordination. It is only available to persons who are residing in a state of Louisiana permanent supportive housing unit.

C. Participants may not exceed 165 combined units of this service and the housing stabilization transition service.

1. Exceptions to the 165 unit limit can only be made with written approval from the OCDD.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:79 (January 2014).

Chapter 141. Self-Direction Initiative

§14101. Self-Direction Service Delivery Option

A. The self-direction initiative is a voluntary, self-determination option which allows the participant to coordinate the delivery of NOW services, as designated by OCDD, through an individual direct support professional rather than through a licensed, enrolled provider agency. Selection of this option requires that the participant utilize a payment mechanism approved by the department to manage the required fiscal functions that are usually handled by a provider agency.

B. Participant Responsibilities. Waiver participants choosing the self-directed service delivery option must understand the rights, risks and responsibilities of managing his/her own care and individual budget. If the participant is unable to make decisions independently, he/she must have an authorized representative who understands the rights, risks and responsibilities of managing his/her care and supports within his/her individual budget. Responsibilities of the participant or authorized representative include:

1. completion of mandatory trainings, including the rights and responsibilities of managing his/her own services and supports and individual budget;

2. participation in the self-direction service delivery option without a lapse in or decline in quality of care or an increased risk to health and welfare; and

a. adhere to the health and welfare safeguards identified by the team, including the application of a comprehensive monitoring strategy and risk assessment and management systems;

3. participation in the development and management of the approved personal purchasing plan:

a. this annual budget is determined by the recommended service hours listed in the participant's POC to meet his/her needs;

b. the participant's individual budget includes a potential amount of dollars within which the participant or his/her authorized representative exercises decision-making responsibility concerning the selection of services and service providers.

C. Termination of the Self-Direction Service Delivery Option. Termination of participation in the self-direction service delivery option requires a revision of the POC, the elimination of the fiscal agent and the selection of the Medicaid-enrolled waiver service provider(s) of choice.

1. Voluntary Termination. The waiver participant may chose at any time to withdraw from the self-direction service delivery option and return to the traditional provider agency management of services.

2. Involuntary Termination. The department may terminate the self-direction service delivery option for a participant and require him/her to receive provider-managed services under the following circumstances:

a. the health or welfare of the participant is compromised by continued participation in the self-direction service delivery option;

b. the participant is no longer able to direct his/her own care and there is no responsible representative to direct the care;

c. there is misuse of public funds by the participant or the authorized representative; or

d. over three consecutive payment cycles, the participant or authorized representative:

i. places barriers to the payment of the salaries and related state and federal payroll taxes of direct support staff;

ii. fails to follow the Personal Purchasing Plan;

iii. fails to provide required documentation of expenditures and related items; or

iv. fails to cooperate with the fiscal agent or support coordinator in preparing any additional documentation of expenditures.

D. All services rendered shall be prior approved and in accordance with the plan of care.

E. All services must be documented in service notes, which describes the services rendered and progress towards the participant's personal outcomes and his/her plan of care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1209 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1651 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:79 (January 2014).

Chapter 142. Provider Participation Requirements

§14201. Electronic Visit Verification

A. Effective for dates of service on or after August 1, 2015, New Opportunities Waiver providers shall use the electronic visit verification (EVV) system designated by the department for automated scheduling, time and attendance tracking, and billing for certain home and community-based services.

B. Reimbursement shall only be made to providers with documented use of the EVV system. The services that require use of the EVV system will be published in the NOW provider manual.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:1287 (July 2015).

Chapter 143. Reimbursement

§14301. Unit of Reimbursement

A. Reimbursement for services shall be a prospective flat rate for each approved unit of service provided to the participant. One quarter hour (15 minutes) is the standard unit of service and reimbursement shall not be made for less than 15 minutes (one quarter hour) of service. This covers both service provision and administrative costs for the following services:

1. center-based respite;
2. community integration development:

a. up to three participants may choose to share community integration development if they share a common provider of this service;

b. there is a separate reimbursement rate for community integration development when these services are shared;

3. day habilitation;
4. employment related training;
5. individualized and family support-day and night;

a. up to three participants may choose to share individualized and family support services if they share a common provider;

b. there is a separate reimbursement rate for individualized and family support when these services are shared;

6. professional services;

7. skilled nursing services:

a. up to three participants may choose to share skilled nursing services if they share a common provider;

b. there is a separate reimbursement rate for skilled nursing services when these services are shared;

c. nursing consultations are offered on an individual basis only.

8. supported employment, one-to-one intensive and mobile crew/enclave;

9. housing stabilization transition; and

10. housing stabilization.

B. The following services are to be paid at cost, based on the need of the participant and when the service has been prior authorized and on the POC:

1. environmental accessibility adaptations;

2. specialized medical equipment and supplies; and

3. transitional expenses.

C. The following services are paid through a per diem:

1. substitute family care;

2. supported living;

3. supported employment-follow along; and

4. adult companion care.

D. Maintenance of the personal emergency response system is paid through a monthly rate.

E. Installation of the personal emergency response system is paid through a one-time fixed cost.

F. Remote assistance is paid through an hourly rate.

G. Direct Support Professionals Wages. The rate paid to direct support professionals shall be the federal minimum wage in effect at the time.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1209 (June 2004), amended by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 34:252 (February 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 35:1851 (September 2009), LR 36:1247 (June 2010), LR 37:2158 (July 2011), LR 39:1049 (April 2013), LR 40:80 (January 2014), LR 42:898 (June 2016).