Subpart 11. New Opportunities Waiver

Chapter 137. General Provisions

§13701. Introduction

A. The New Opportunities Waiver (NOW), hereafter referred to as the NOW, is designed to enhance the home and community-based 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 the NOW is to utilize the principle of self-determination and supplement the family and/or community supports while supporting the dignity, quality of life and security in the everyday life of an individual, and maintaining that individual in the community. Services provided in the NOW are community-based, and are designed to allow an individual experience that mirrors the experiences of individuals without disabilities. These services are not to be restrictive, but liberating, by empowering individuals to experience life in the most fulfilling manner as defined by the individual while still assuring health and safety. 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.

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 comprehensive plan of care (CPOC). The CPOC shall be developed using a person-centered process coordinated by the participant'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 unless otherwise allowed in rule. The service must be documented in service notes describing the service rendered and progress towards the participant's personal outcomes and CPOC.

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

1. substitute family care;
2. supported independent living; and
3. skilled nursing services.

a. Skilled nursing services may only be provided with:

i. substitute family care;

ii. supported independent living;

iii. day habilitation;

iv. supported employment (all three modules); and/or

v. prevocational services

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), amended by the Department of Health, Bureau of Health

Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:50 (January 2018), LR 45:42 (January 2019), LR 46:1680 (December 2020).

§13702. Settings for Home and Community-Based Services

A. NOW participants are expected to be integrated in and have full access to the greater community while receiving services, to the same extent as individuals without disabilities. Providers shall meet the requirements of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' (CMS) home and community-based setting requirements for Home and Community-Based Services (HCBS) Waivers as delineated in LAC 50:XXI.901.

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, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:51 (January 2018).

§13703. Participant Qualifications and Admissions Criteria

A. In order to qualify for the New Opportunities Waiver (NOW), an individual must be three years of age or older and meet all of the following criteria:

1. have an intellectual and/or developmental disability as specified in R.S. 28:451.2;

2. be deemed eligible for developmental disability services and be on the intellectual/developmental disabilities (IDD) 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, based on a uniform needs-based assessment and a person-centered planning discussion that the NOW is the only OCDD waiver that will meet the needs of the individual;

7. be a resident of Louisiana; and

8. be a citizen of the United States or a qualified immigrant.

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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2528 (December 2017), LR 45:43 (January 2019).

§13704. Needs-Based Assessment

A. A uniform needs-based assessment in conjunction with person-centered planning is utilized in the service planning process for the individuals receiving or participating in an OCDD waiver. The results of this assessment activity shall be utilized to determine which OCDD waiver will be offered to the individual during the initial plan of care process.

1. The participant or his/her representative may request a reconsideration and present supporting documentation if he/she disagrees with the specific OCDD waiver offered as a result of the needs based assessment and person-centered planning process. If the participant disagrees with the reconsideration decision, he/she may request a fair hearing through the formal appeals process.

B. The needs-based assessment instrument(s) is designed to evaluate the practical support requirements of individuals with developmental disabilities in daily living, medical and behavioral areas, including:

1. home living;

2. community living;

3. lifelong learning;

4. employment;

5. health and safety;

6. social activities; and

7. protection and advocacy.

C. The needs-based assessment instrument(s) is also used to evaluate the individual's support needs based on information and data obtained from four areas of the person's life, which includes:

1. support needs measurements including:

a. material support;

b. vision related supports;

c. hearing related supports;

d. supports for communicating needs;

e. positive behavior supports;

f. physicians supports;

g. professional supports (e.g., registered nurse, physical therapist, occupational therapist, etc.); and

h. stress and risk factors;

2. living arrangements and program participation including:

a. people living in the home;

b. natural supports in the home;

c. living environments; and

d. supports and service providers;

3. medical and diagnostic information findings including:

a. diagnoses;

b. medications and dosages; and

c. need for relief from pain or illness; and

4. personal satisfaction reports including:

a. agency supports provided at home;

b. work or day programs;

c. living environment;

d. family relationships; and

e. social relationships.

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 Service Financing and the Office for Citizens with Developmental Disabilities, LR 36:65 (January 2010), amended LR 40:69 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2528 (December 2017).

§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 comprehensive 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;

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; and/or

9. there is no justification, based on a uniform needs-based assessment and a person-centered planning discussion, that the NOW is the only OCDD waiver that will meet the participant's needs.

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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:51 (January 2018), LR 45:43 (January 2019).

§13706. Resource Allocation

A. The resource allocation model shall be used to assign service units based on the findings of the needs-based assessment and person-centered planning discussion for individuals who will be offered or are currently receiving New Opportunities Waiver services. Within the resource allocation model, there is a determination of an acuity level for individual and family support (IFS) services.

1. The participant or his/her representative may request a reconsideration and present supporting documentation if he/she disagrees with the amount of assigned IFS service units. If the participant disagrees with the reconsideration decision, he/she may request a fair hearing through the formal appeals process.

2. Implementation of the resource allocation model was phased-in for the allocation of new NOW opportunities and renewal of existing NOW opportunities beginning July 1, 2009.

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, Bureau of Health Service Financing and the Office for Citizens with Developmental Disabilities, LR 43:2528 (December 2017).

§13707. Programmatic Allocation of Waiver Opportunities

A. The intellectual/developmental disabilities request for services registry, hereafter referred to as "the registry," shall be used to identify persons with intellectual and/or developmental disabilities who are waiting for an OCDD waiver opportunity.

B. Individuals who are found eligible for developmental disabilities services using standardized tools, and who request waiver services will be added to the registry. The request for services registry (RFSR) is arranged by the urgency of need and date of application for developmentally disabled (DD) waiver services.

C. Funded OCDD waiver opportunities will be offered based on the following priority groups:

1. individuals living at Pinecrest Supports and Services Center or in a publicly-operated ICF-ID when it was transitioned to a private ICF-ID through a cooperative endeavor agreement, or their alternates. *Alternates* are defined as individuals living in a private ICF-ID who will give up the private ICF-ID bed to an individual living at Pinecrest or to an individual who was living in a publicly-operated ICF-ID when it was transitioned to a private ICF-ID through a cooperative endeavor agreement. Individuals requesting to transition from either facility listed above are awarded the appropriate waiver when one is requested, and their health and safety can be assured in an OCDD home and community-based waiver program:

a. the bed being vacated by the alternate in the private ICF-ID 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-ID is to occur as close as possible to the actual discharge of the alternate from the private ICF-ID 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-ID provider;

b. the funded waiver opportunity will be reserved for a period not to exceed 120 days; however, this 120-day period may be extended as needed;

2. individuals on the registry who have the highest level of need and the earliest registry date shall be notified in writing when a funded OCDD waiver opportunity is available and that he/she is next in line to be evaluated for a possible waiver assignment.

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.

E. Funded waiver opportunities will only be allocated to individuals who successfully complete the financial and medical eligibility process required for waiver certification.

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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2529 (December 2017).

Chapter 139. Covered Services

§13901. Individual and Family Support Services

A. Individual and family support (IFS) services are direct support and assistance services, provided in the participant's home or in the community, that allow the participant to achieve and/or maintain increased independence, productivity, enhanced family functioning and inclusion in the community to the same degree as individuals without disabilities. IFS services are also used to provide relief to the primary caregiver. 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 COPC.

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 as outlined in the CPOC.

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 CPOC.

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 and are outlined in the CPOC. 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 CPOC 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 CPOC 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 CPOC.

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 CPOC and based on an individual-by-individual determination and choice. 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; and

i. any medical task which can be delegated;

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

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/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 CPOC or granted in writing by the OCDD Waiver director/designee.

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 Department of Health 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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:51 (January 2018).

§13902 Individual and Family Support Supplemental Payments

A. Supplemental payments will be made to licensed HCBS providers with a PCA module who support individuals currently receiving qualified waiver services who have complex medical and/or behavioral needs and are at a higher risk of institutionalization.

1. The integration of the supplemental payment provides additional funding to licensed HCBS providers with a PCA module who provide supports that focus on the prevention of deteriorating or worsening medical or behavioral conditions for individuals with complex needs.

2. The provider will be required to complete a screening tool and submit initial documentation as outlined in the program manual prior to qualifying for any supplemental payment. The supplemental payment will be re-evaluated annually to determine ongoing need per program requirements.

3. The PCA providers must be licensed home and community-based services (HCBS) providers with a personal care attendant module in order to receive the supplemental payment, in addition to the criteria listed in §13902 B.

B. Determination Process: A PCA provider can qualify for a supplemental payment if the individual currently receiving qualified waiver services has a complex medical and/or behavioral need.

1. Complex Medical

a. Individuals must require at least two of the following non-complex tasks delegated by a registered nurse to a non-licensed direct service worker:

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

ii. care of a mature tracheostomy site;

iii. removing/cleaning/replacing inner tracheostomy cannula for mature tracheostomy;

iv. providing routine nutrition, hydration or medication through an established gastrostomy or jejunostomy tube (excludes nasogastric tube);

v. clean intermittent urinary catheterization;

vi. obtaining a urinary specimen from a port of an indwelling urinary catheter;

vii. changing a colostomy appliance;

viii. ensuring proper placement of nasal cannula (excludes initiation/changing of flow rate;

ix. capillary blood glucose testing;

x. simple wound care (including non-sterile/clean dressing removal/application); or

xi. other delegable non-complex tasks as approved by OCDD in accordance with LAC 48:1 Chapter 92 Subchapter D.

2. Behavioral

a. The individual meets two of the following items:

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

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

iii. a supervised period of time away, outside of the individual's weekly routine, such as work, school or participation in his/her community, is needed at least once per week; and

b. the individual requires one of the following due to the items listed in Subparagraph a.-a.iii above:

i. higher credentialed staff (college degree, specialized licensing, such as registered behavior technician [RBT], applied behavior analysis [ABA], etc.), who have advanced behavioral training for working with individuals with severe behavioral health symptoms or significant experience working with this population; or

ii. the need for higher qualified supervision of the direct support of staff (master's degree, additional certification, such as board certified behavior analyst [BCBA], etc.).

C. The supplemental payment is not allowed for waiver participants who do not receive individual and family support (IFS) services.

D. The supplemental payment may not be approved for waiver participants receiving IFS hours in addition to 12 or more hours of skilled nursing per day.

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, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:1681 (December 2020).

§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 CPOC 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 Department of Health 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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:51 (January 2018).

§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 comprehensive 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 a shared supports worker for up to three waiver participants who have a common direct service provider agency. 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 CPOC year which includes the combination of shared and non-shared community integration development.

D. Provider Qualifications. Providers must be licensed by the Department of Health 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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:52 (January 2018).

§13907. Supported Independent Living

A. Supported independent living (SIL) 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. SIL 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. SIL 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 SIL workers provided they meet the same qualifications as any other SIL worker.

C. Exclusions

1. Legally responsible persons may not be SIL providers for the individual whom they are legally responsible.

2. SIL 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. SIL services cannot be provided in a substitute family care setting.

D. Service Limit. SIL services are limited to one service per day, per CPOC year, except when the participant is in center-based respite. When a participant living in an SIL setting is admitted to a center-based respite facility, the SIL provider shall not bill the SIL 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 Department of Health 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 SIL agency include two documented contacts per week and one documented face-to-face contact per month by the SIL provider agency in addition to the approved direct support hours. These required contacts must be completed by the SIL agency supervisor so designated by the provider agency due to the experience and expertise relating to the participants' needs or a licensed/certified professional qualified in the state of Louisiana who meets requirements as defined by 42 CFR §483.430 or any subsequent regulation.

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

3. Supported independent living services shall be coordinated with any services listed in the approved CPOC, 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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:52 (January 2018).

§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 substitute family care home that meets all licensing requirements for the substitute family care module. 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. Only two SFC participants may reside in a single SFC setting at the same time. There shall be no more than three persons living in a substitute family care setting who are unrelated to the SFC 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 CPOC. Participants living in an SFC home may receive IFS services.

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

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

D. Provider Qualifications. Providers must be licensed by the Department of Health 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), amended by the Department of Health, Bureau of Health Services Financing and

the Office for Citizens with Developmental Disabilities, LR 44:52 (January 2018).

§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 CPOC. Day habilitation services are provided in a variety of community settings, (i.e. local recreation department, garden clubs, libraries, etc.) other than the person's residence and are not limited to a fixed-site facility.

1. Day habilitation services must be directed by a person-centered service plan and provide the participant choice in how they spend their day. The activities should assist the participant to gain their desired community living experience, including the acquisition, retention or improvement in self-help, socialization and adaptive skills, and/or to provide the individual an opportunity to contribute to and be a part of his or her community.

2. Day habilitation services shall be coordinated with any therapy, prevocational service, 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.

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

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 CPOC year.

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

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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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:53 (January 2018).

§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 eligible and assessed to need the service in order to receive supported employment services. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which an individual is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

B. Individuals eligible for Louisiana Rehabilitation Services (LRS) must access those services prior to utilizing home and community based waiver supported employment services.

C. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment cannot be provided at worksites that are facility based, or other similar types of vocational services furnished in specialized facilities that are not part of the general workplace. 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 may include 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 through formation of natural supports. 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 24 days per CPOC year.

3. Mobile work crew/enclave is an employment setting in which a group of two or more participants, but no more 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 independent 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 participants 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 participants who are eligible and have been accepted 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 one quarter hour units per CPOC 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 24 days per CPOC year.

3. Mobile crew/enclave services shall not exceed 8,320 one quarter hour units of service per CPOC 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 or be licensed by the Department of Health 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 30:1205 (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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:53 (January 2018).

§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. 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 Department of Health 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.

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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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:54 (January 2018).

§13917. Prevocational Services

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

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

a. the ability to communicate effectively with supervisors, co-workers, and customers;

b. accepted community workplace conduct and dress;

c. the ability to follow directions and attend to tasks;

d. workplace problem solving skills and general workplace safety; and

e. mobility training.

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

prevocational services, but may not comprise the entirety of the service.

B. Prevocational services are provided on a regularly scheduled basis and may be scheduled on a comprehensive plan of care for one or more days per week and may be prior authorized for up to 8,320 units of service in a plan year with appropriate documentation. A standard unit is one quarter hour.

C. Exclusions. The following service exclusions apply to prevocational services.

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 CPOC year. Additionally, prevocational services are time limited to four years, after which the participant should be able to transition into employment. Exceptions to the four-year limitation may be approved at the discretion of OCDD program office.

E. Licensing Requirements. Providers must be licensed by the Department of Health 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 30:1205 (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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:55 (January 2018).

§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 accepted by the participant/authorized representative in the CPOC year for which it was approved. The environmental accessibility adaptation(s) must be billed and reimbursed according to the Medicaid billing guidelines established by LDH policy. 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. Car seats are not considered a vehicle adaptation.

D. Service Limits. There is a cap of $7,000 per three year period for a participant for environmental accessibility adaptations. 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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:55 (January 2018).

§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 three year period for a participant for specialized equipment and supplies. 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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:56 (January 2018).

§13923. Personal Emergency Response Systems

A. Personal emergency response systems (PERS) is a rented electronic device connected to the person's phone and programmed to signal a response center which enables a participant to secure help in an emergency.

B. Participant Qualifications. Personal emergency response systems (PERS) services are available to those persons who:

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

2. are unable to use other communication systems as they are not adequate to summon emergency assistance; or

3. do not have 24 hour direct supervision.

C. Coverage of the PERS is limited to the rental of the electronic device. PERS services shall include the cost of maintenance and training the participant to use the equipment.

D. 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.

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

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).

§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, 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 CPOC 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 CPOC.

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 CPOC.

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 CPOC year for the combined range of 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 comprehensive 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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:56 (January 2018).

§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 CPOC. 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 CPOC 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 CPOC. Nursing consultations are offered on an individual basis only.

C. Provider Qualifications. The provider must be licensed by the Department of Health as a home health agency.

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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:56 (January 2018)., LR 46:1681 (December 2020).

§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 of their choice 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. The participants must be allowed choice in the items purchased.

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, 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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:56 (January 2018).

§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 an individual who lives independently and can manage his/her own household with limited supports. The companion is a principal care provider chosen by the participant, who provides services in the participant's home and lives with the participant as a roommate. Adult companion care services are furnished through a licensed provider organization as outlined in the participant's CPOC. This service includes:

1. providing assistance with all of the activities of daily living as indicated in the participant's CPOC;

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 setting is the participant's home which should have been freely chosen by the participant from among non-disability specific settings and not owned or controlled by the provider. The companion is an employee or contractor of the provider organization and is responsible for providing limited, daily direct services to the 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 the participant's spouse or legal guardian.

C. Provider Responsibilities

1. The provider organization shall develop a written agreement as part of the participant's CPOC 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 comprehensive 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 CPOC.

D. Companion Responsibilities

1. The companion is responsible for:

a. participating in, and abiding by, the CPOC;

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 365 days per year as documented in the participant's CPOC.

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 independent living;

b. individual and family support;

c. substitute family care; or

d. skilled nursing.

G. Provider Qualifications. Providers must be licensed by the Department of Health 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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:57 (January 2018), repromulgated LR 44:282 (February 2018).

§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 setting for the permanent supportive housing must be integrated in the greater community, and support full access to the greater community by the participant. 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 of the participant's choice, including non-disability specific settings;

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 comprehensive 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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:57 (January 2018).

§13937. Housing Stabilization Service

A. Housing stabilization service enables waiver participants to maintain their own housing as set forth in the participant's approved CPOC. 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 CPOC, 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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:57 (January 2018).

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

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 CPOC 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 CPOC, 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 choose 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 comprehensive 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 comprehensive 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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:58 (January 2018).

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).

§14202. Incident Reporting, Tracking and Follow-Up

A. The direct service provider is responsible for responding to, reviewing, and remediating incidents that occur to the participants they support. Direct service providers must comply with any other rules promulgated by the LDH regarding incident reporting and response.

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, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:58 (January 2018).

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. prevocational services;

5. individual 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 CPOC:

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 independent living;

3. supported employment-follow along;

4. adult companion care; and

5. individual and family support supplemental payment.

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. Direct Support Worker Wages

1. Establishment of Direct Support Worker Wage Floor for Medicaid Home and Community-Based Services for Intellectual and Developmental Disabilities

a. Effective October 1, 2021, providers of Medicaid home and community-based waiver services operated through the Office for Citizens with Developmental Disabilities employing defined direct support workers will receive the equivalent of a $2.50 per hour rate increase.

b. Effective October 1, 2021, this increase or its equivalent will be applied to all service units provided by direct support workers with an effective date of service for the identified home and community based waiver services provided beginning October 1, 2021.

c. The minimum hourly wage floor paid to direct support workers shall be $9.00 per hour.

d. All providers of services affected by this rate increase shall be subject to a direct support worker wage floor of $9.00 per hour. This wage floor is effective for all affected direct support workers of any work status (full-time, part-time, etc.)

e. The Department of Health reserves the right to adjust the direct support worker wage floor as needed through appropriate rulemaking promulgation consistent with the Louisiana Administrative Procedure Act.

2. Establishment of Audit Procedures for Direct Support Worker Wage Floor

a. The wage enhancement payments reimbursed to providers shall be subject to audit by the department.

b. Providers shall provide to the department or its representative all requested documentation to verify compliance with the direct support worker wage floor.

c. This documentation may include, but not be limited to, payroll records, wage and salary sheets, check stubs, etc.

d. Providers shall produce the requested documentation upon request and within the time frame provided by the department.

e. Noncompliance or failure to demonstrate that the wage enhancement was paid directly to direct support workers may result in:

i. sanctions; and

ii. disenrollment in the Medicaid Program.

3. Sanctions

a. The provider will be subject to sanctions or penalties for failure to comply with this Rule or with

requests issued by LDH pursuant to this Rule. The severity of such action will depend on:

i. failure to pay I/DD HCBS direct support workers the floor minimum of $9.00 per hour;

ii. the number of employees identified as having been paid less than the $9.00 per hour floor; or

iii. the persistent failure to pay the floor minimum of $9.00 per hour.

iv. failure to provide LDH with any requested documentation or information related to or for the purpose of verifying compliance with this Rule.

4. New Opportunities Waiver Fund

a. The department shall deposit civil fines and the interest collected from providers into the New Opportunities Waiver Fund.

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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:58 (January 2018), LR 45:44 (January 2019), LR 46:1682 (December 2020), LR 48:41 (January 2022).