# Subpart 13. Residential Options Waiver

## Chapter 161. General Provisions

### §16101. Introduction

A. The Residential Options Waiver (ROW), a 1915-C waiver, is designed to enhance the long term services and supports available to individuals with developmental disabilities. These individuals would otherwise require an intermediate care facility for the mentally retarded (ICF/MR) level of care.

B. The goal of the Residential Options Waiver is to promote independence through strengthening the individual's capacity for self-care, self-sufficiency and community integration utilizing a wide array of services, supports and residential options which best meets the individual's needs and preferences.

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 for Citizens with Developmental Disabilities, LR 33:2441 (November 2007).

### §16103. Program Description

A. The ROW is designed to utilize the principles of self determination and to supplement the family and/or community supports that are available to maintain the individual in the community. In keeping with the principles of self-determination, ROW includes a self-direction option. This allows for greater flexibility in hiring, training and general service delivery issues.

B. The objectives of the ROW are to:

1. promote independence for recipients through the provision of services meeting the highest standards of quality and national best practices while ensuring health and safety through a comprehensive system of recipient safeguards;

2. offer an alternative to institutional care through the provision of an array of services and supports that promote community living, community inclusion and independence by enhancing, and not replacing, existing informal networks;

3. support recipients and their families in exercising their rights and sharing responsibility for their programs regardless of the method of service delivery; and

4. offer access to services on a short-term basis that would protect the health and safety of the recipient if the family or other care giver were unable to continue to provide care and supervision.

C. All of the services provided in the ROW are accessed through a single point of entry within the Office for Citizens with Developmental Disabilities (OCDD).

D. All services must be prior authorized. Prior authorization is completed through an independent entity contracted by the Department of Health and Hospitals.

E. All services must be delivered in accordance with the approved Individual Support Plan (ISP). The ISP shall be developed using a person-centered process coordinated by the support coordination agency.

1. Waiver recipients choose their support coordination and direct service provider agencies through a freedom of choice process.

F. The total expenditures available for each waiver recipient is established through an assessment of individual support needs and will not exceed the approved ICF/MR rate established for that individual.

G. No reimbursement for ROW services shall be made for a recipient who is admitted to an inpatient setting.

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 for Citizens with Developmental Disabilities, LR 33:2441 (November 2007).

**§16105. Recipient Qualifications**

A. In order to qualify for services through the ROW, an individual must meet the definition for a developmental disability as defined in R.S. 28:451.2(12)(a)(b).

B. The individual must:

1. be a Louisiana resident and a citizen of the United States or a qualified alien;

2. meet the requirements for an ICF/MR level of care which requires active treatment for developmental disabilities under the supervision of a qualified mental retardation professional;

3. meet the financial eligibility requirements for the Medicaid Program as a member of the group of individuals who would be eligible for Medicaid if they:

a. were in a medical institution; or

b. need home and community-based services in order to remain in the community; and

c. have a special income level equal to 300 percent of the Supplemental Security Income (SSI) federal benefit rate; and

C. Assurances are required that the health, safety and welfare of the individual can be maintained in the community with the provision of ROW services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2441 (November 2007).

**§16107. Programmatic Allocation of Waiver Opportunities**

A. The Request for Services Registry, hereafter referred to as "the registry", shall be used to evaluate individuals for the Residential Options Waiver and to fill all waiver opportunities for persons with developmental disabilities. The next individual on the registry shall be notified in writing that a waiver opportunity is available and that he is next in line to be evaluated for a possible waiver assignment. The individual shall then choose a support coordination agency that will assist in the gathering of the documents needed for both the financial eligibility and medical certification process for the level of care determination. If the individual is determined to be ineligible, either financially or medically, that individual shall be notified in writing. The next individual on the registry shall be notified, as stated above, and the process continues until an eligible individual is assigned the waiver opportunity. A waiver opportunity shall be assigned to an individual when eligibility is established and the individual is certified.

B. Right of Refusal. An individual may be designated inactive on the registry upon written request to OCDD. When the individual determines that he is ready to begin the waiver evaluation process, he shall request, in writing, that his name be removed from inactive status. His original protected request date will be reinstated.

C. Utilizing the procedures described in subparagraph A, ROW opportunities will be offered with priority given to the individuals in the following groups:

1. participants in the Money Follows the Person Rebalancing Demonstration Grant of 2007 which includes:

a. residents of nursing facilities who have developmental disabilities and whose care is reimbursed at the rates established for infectious disease or technology dependent care;

b. residents of private ICFs/MR who choose to receive home and community-based waiver services and the providers voluntarily closes the licensed, Medicaid enrolled ICF/MR beds vacated by the individuals in order to fund ROW opportunities; and

c. residents of public ICFs/MR who are in licensed Medicaid enrolled beds and have chosen to receive home and community-based waiver services;

2. residents of six bed private ICFs/MR who choose to receive home and community-based waiver services and the providers voluntarily closes the licensed, Medicaid enrolled ICF/MR beds vacated by the individuals in order to fund ROW opportunities;

3. individuals served in the Host Home contracts as identified by OCDD or persons served in existing OCDD Host Home contracts as of the effective date of the ROW; and

4. the remaining opportunities will be allocated equally among the following groups, with any unused opportunities from these groups being equally distributed among the remaining groups:

a. 25 percent will be reserved for crisis diversion for those qualifying individuals who meet the criteria for emergency waiver opportunities;

b. 25 percent will be reserved for individuals with developmental disabilities who reside in nursing facilities and do not meet the criteria in subparagraph C.1.a.;

c. 25 percent will be reserved for residents of private ICFs/MR, based on their registry protected date and on a first-come, first-served basis; and

d. 25 percent reserved capacity for qualifying individuals who request the ROW, based on their registry protected date and on a first-come, first-served basis.

D. Crisis Diversion or Emergency Waiver Opportunities. Requests for crisis diversion or emergency waiver opportunities shall be made through the regional administrative units (RAU) which are local and regional governmental entities responsible for coordination of services for individuals with developmental disabilities. To be considered for a crisis diversion or emergency waiver opportunity, the individual must need long-term supports, not temporary or short-term supports. All of the following criteria shall be used in the determination of priority for a crisis diversion or emergency waiver opportunity.

1. Urgency of Need. The individual will require further assessment for emergency services if one of the following situations exists:

a. the caregiver is unable or unwilling to continue providing care;

b. death of the caregiver and there are no other available supports;

c. the caregiver is incapacitated and there are no other available supports due to physical or psychological reasons;

d. intolerable temporary placement and immediate need for new placement; or

e. other family crisis exists with no caregiver support available.

2. Level of Risk. The individual will be assessed to determine the risk to his health and safety in areas of daily living, health care and behavioral supports if an emergency waiver opportunity is not made available. Level of risk will be categorized as follows:

a. High Risk. The individual's health or safety is at imminent risk without the requested developmental disability supports.

b. Moderate Risk. The individual has a potential risk of losing his current level of health or safety without the requested developmental disability supports.

c. Low Risk. The individual is at little or no risk of losing his current level of health or safety without the requested developmental disability supports.

3. Level of Unmet Needs. The individual's needs shall be identified and assessed to determine the level to which the needs are being met.

4. Adaptive Service Level Determination. The individual's service needs will be determined utilizing a standardized rating based on adaptive behavior levels.

5. Financial Resources Determination. Individual or family income shall be considered to determine whether it is adequate to meet unmet needs.

E. Individuals who enter the ROW and are on the RFSR for the NOW will retain their protected date for the NOW until July 1, 2008.

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 for Citizens with Developmental Disabilities, LR 33:2441 (November 2007).

**§16109. Discharge Criteria**

A. Discharge Criteria. Recipients shall be discharged from the Residential Options Waiver if one of the following criteria is met:

1. loss of Medicaid financial eligibility;

2. loss of eligibility for an ICF/MR level of care;

3. incarceration or placement under the jurisdiction of penal authorities, courts or state juvenile authorities;

4. change of residence to another state;

5. admission to an ICF/MR or nursing facility with the intent to stay and not to return to waiver services;

6. the health and welfare of the waiver recipient cannot be assured in the community through the provision of reasonable amounts of waiver services, i.e., the waiver recipient presents a danger to himself or others;

7. failure to cooperate in either the eligibility determination process or the initial or annual implementation of the approved ISP or the responsibilities of the ROW recipient; or

8. continuity of services is interrupted as a result of the recipient not receiving ROW services during a period of 30 consecutive days.

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 for Citizens with Developmental Disabilities, LR 33:2443 (November 2007).

# Chapter 163. Covered Services

**§16301. Assistive Technology**

A. Assistive Technology services enable individuals to increase, maintain or improve their ability to function more independently in their home or communities through the use of devices, controls and appliances specified in their ISP. This service also includes service(s) that directly assists recipients in the selection, acquisition, or use of an assistive technology device.

B. Assistive Technology services provided through the ROW includes the following services:

1. evaluation of the assistive technology needs of a recipient, including a functional evaluation of the impact of appropriate assistive technology services to the recipient in their customary environment;

2. purchase or lease of assistive technology devices for recipients, including adaptation, maintenance and replacement as necessary. This includes battery purchases and other reoccurring replacement items that contribute to ongoing maintenance of these devices;

3. coordination and use of necessary therapies, interventions or services with assistive technology devices associated with other services in the ISP;

4. training or technical assistance for the recipient, or where appropriate, the recipient's family members, legal guardian or responsible representative in the use and maintenance of devices, controls and appliances;

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

6. service contracts and other warranties; and

7. repair of all items purchased.

a. Separate payment will be made for repairs after expiration of the warranty when cost effective.

C. Assistive technology equipment covered through ROW may include the following devices:

1. assistive devices for individuals who are deaf or hearing impaired including:

a. visual alarms;

b. telecommunications devices for the deaf (TDDs);

c. telephone amplifying devices; and

d. other devices for the protection of health and safety;

2. assistive devices for individuals who are

blind or visually impaired including:

a. tape recorders;

b. talking calculators;

c. magnifiers;

d. Braille writers;

e. talking computerized devices; and

f. other devices for the protection of health and safety;

3. environmental controls including devices to operate appliances, use telephones or open doors;

4. assistive devices for individuals with fine motor limitations including:

a. living and recreational home aides such as reachers, adaptive cooking devices and adapted games.

b. employment or school aides such as book holders, adapted writing devices, page turners and fine motor devices;

5. assistive devices for individuals with sensory processing disorder including multi-sensory devices such as bubble tubes, vestibular swings and tactile boards;

6. control interfaces to assist the person in controlling assistive technology such as keyboards and head and mouth sticks; and

7. other devices, controls, appliances specified in the recipient's ISP which are used to increase, maintain or improve his ability to function more independently in his home or community.

D. All assistive technology items must meet applicable manufacture, design and installation requirements.

E. Service Exclusions. Assistive technology devices that are of general utility or maintenance and have no direct medical or remedial benefit to the individual are excluded from coverage in the ROW.

F. Provider Qualifications. In order to enroll to participate in the Medicaid Program, assistive technology providers must furnish written documentation of authorization to sell, install and/or repair technological equipment and supplies from the respective manufacturer of the designated 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 for Citizens with Developmental Disabilities, LR 33:2443 (November 2007).

**§16303. Community Living Supports**

A. Community Living Supports (CLS) are services provided to assist individuals with residing successfully in an individual or family home and to help them achieve and maintain the outcomes of increased independence, productivity and inclusion in the community. Utilizing teaching and support strategies, CLS focuses on achieving one or more of the goals outlined in the recipient's approved ISP. These services may be furnished through self-direction or through a licensed, enrolled agency.

B. Community Living Supports are related to acquiring, retaining and improving independence, autonomy and adaptive skills. CLS may include the following services:

1. direct support services or self-help skills training for the performance of all the activities of daily living and self-care;

2. socialization skills training which is intended to foster community inclusion and well-being, such as involvement in community recreational and leisure activities;

a. CLS providers may provide out-of-home support, community-integration planning (event/location identification and scheduling), transportation, travel training not related to vocational or habilitative services, or other supports needed for socialization skills development.

3. cognitive, communication tasks, adaptive skills which may include homemaker tasks, safety skills, recognition of basic concepts, academic skills (outside of those skills mandated by the local education agency) and a variety of interpersonal communication objectives; and

a. CLS providers may work collaboratively with natural supports, the support coordinator, habilitation and vocational providers or professional services providers to identify areas that connect with the individual's choice of daily routine.

4. replacement behavior components which include those skills required to effectively address situations and antecedents of frequently occurring maladaptive or challenging behavior;

a. CLS providers may work, as directed by an assigned professional, to assist the person to develop skills necessary to reduce or eliminate episodes in which the individual becomes a danger to self or others.

b. The provider of this service shall provide 24-hour back-up and emergency staff to meet unpredictable needs of recipients in a way that promotes maximum dignity and independence while enhancing supervision, safety and security.

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

D. Community Living Supports may be shared by up to three recipients who may or may not live together, and who have a common direct service provider. Recipients may share CLS staff when agreed to by the recipients, or their legal guardian, and when the health and welfare of each recipient can be assured.

1. The shared staff must be reflected on the recipients' Individual Support Plans and based on an individual-by-individual determination.

2. A shared rate must be billed when CLS staff is shared.

E. Service Exclusions

1. Staff providing services may not sleep during billable hours of Community Living Supports.

2. Routine care and supervision that is normally provided by the recipient's spouse or family, and services provided to a minor by the child's parent or step-parent, are not covered in the ROW.

3. The recipient may not live in the same home as CLS staff.

4. Room and board or maintenance, upkeep and improvement of the individual's or family's residence is not covered in the ROW.

5. Community Living Supports shall not be provided in a licensed respite care facility. Providers cannot bill for CLS provided at the same time, on the same day, as respite services are provided.

6. Community Living Supports services are not available to individuals receiving the following services:

a. Shared Living Conversion;

b. Shared Living;

c. Host Home; or

d. Companion Care.

7. Community Living Supports cannot be provided at the same time that the recipient is receiving the following services:

a. Day Habilitation;

b. Prevocational; or

c. Supported Employment.

F. Provider Qualifications. CLS providers must possess a current, valid license as a Personal Care Attendant Agency.

1. Family members who provide CLS services must meet the same standards as providers who are unrelated to the recipient.

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 for Citizens with Developmental Disabilities, LR 33:2443 (November 2007).

**§16305. Companion Care**

A. Companion Care services assist the recipient to achieve and/or maintain the outcomes of increased independence, productivity and inclusion in the community. These services are designed for individuals who live independently and can manage their own household with limited supports. The companion is a principal care provider who provides services in the recipient's home and lives with the recipient as a roommate. Companion Care services may be furnished through self-direction or through a licensed provider organization as outlined in the recipient's ISP. This service includes:

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

2. 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. Companion Care services are arranged by provider organizations that are subject to licensure. The companion is an employee of the provider organization and is responsible for providing limited, daily direct services to the recipient.

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 be provided may be provided by a family member who is not the recipient's spouse, legally responsible relative or legal guardian.

C. Provider Responsibilities

1. The provider organization shall develop a written agreement as part of the recipient's ISP which defines all of the shared responsibilities between the companion and the recipient. 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 ISP Team. Revisions may occur at the request of the recipient, the companion, the provider or other ISP 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 recipient'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 recipient's Individual Support Plan; and

d. providing 24-hour oversight and supervision of the 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 recipient 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 recipient 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 recipient's ISP.

D. Companion Responsibilities

1. The companion is responsible for:

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

b. maintaining records in accordance with State and provider requirements; and

c. purchasing his own food and personal care items.

E. Service Limits

1. Companion Care services may be authorized for up to 360 hours per year as documented in the recipient's ISP.

F. Service Exclusions

1. Separate payment will not be made for Community Living Supports since these services are integral to, and inherent in, the provision of Companion Care services.

2. Separate payment will not be made for the following residential service models if the recipient is receiving Companion Care services:

a. Respite Care Service–Out of Home;

b. Shared Living;

c. Shared Living-Conversion; or

d. Host Home.

G. Provider Qualifications. The provider agency must be licensed as a Personal Care Attendant 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 for Citizens with Developmental Disabilities, LR 33:2444 (November 2007).

**§16307. Day Habilitation Services**

A. Day Habilitation services are aimed at developing activities and/or skills acquisition to support or further community integration opportunities outside of an individual's home. These activities shall promote independence, autonomy and assist the recipient with developing a full life in his community. The primary focus of Day Habilitation services is acquisition of new skills or maintenance of existing skills based on individualized preferences and goals.

1. The skill acquisition and maintenance activities should include formal strategies for teaching the individualized skills and include the intended outcome for the individual.

2. Individualized progress for the skill acquisition and maintenance activities should be routinely reviewed and evaluated, with revisions made as necessary to promote continued skill acquisition.

3. As an individual develops new skills, his training should move along a continuum of habilitation services offered toward greater independence and self-reliance.

B. Day Habilitation Services shall:

1. focus on enabling individuals to attain their maximum skills;

2. be coordinated with any physical, occupational or speech therapies listed in the recipient's ISP;

3. serve to reinforce skills or lessons taught in school, therapy or other settings; and

4. be furnished on a regularly scheduled basis for one or more days per week;

a. services may be furnished either half-day (over 2 and up to 4 hours per day) or full-day (over 4 hours per day) based on time spent on-site by the recipient.

C. Service Exclusions

1. The provider is responsible for all transportation related to provision of the service, but is not responsible for transportation to and from the recipient's home.

2. Time spent in traveling to and from the habilitation program site shall not be included in the calculation of the total number of service hours provided per day.

a. Travel training for the purpose of teaching the recipient how to use transportation services may be included in determining the total service numbers hours provided per day, but only for the period of time specified in the recipient's ISP.

3. Billing may be made for only one habilitative or vocational service per day.

4. Day Habilitation services cannot be billed for the same time as any of the following services:

a. Community Living Supports;

b. Professional Services, except those direct contacts needed to develop a behavioral management plan; or

c. Respite Care Services–Out of Home.

D. Provider Qualifications. Providers must be licensed as an Adult Day Care Agency or certified by the Louisiana Rehabilitation Services as a Community Rehabilitation 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 for Citizens with Developmental Disabilities, LR 33:2445 (November 2007).

**§16309. Dental Services**

A. Dental services available through the ROW include:

1. comprehensive oral examinations;

2. x-ray films;

3. cleanings;

4. scalings;

5. root canals;

6. crowns;

7. surgical and non-surgical extractions;

8. sedations and anesthesia;

9. topical fluoride treatments; and

10. full or partial dentures.

B. Service Exclusion. Recipients must first access dental services covered under the Medicaid State Plan before utilizing dental services through the Residential Options Waiver.

C. Provider Qualifications. Providers must have a current, valid license to provide dental services from the Louisiana State Board of Examiners for Dentistry for the specific dental services in all specialty areas provided to the recipient.

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 for Citizens with Developmental Disabilities, LR 33:2445 (November 2007).

**§16311. Environmental Accessibility Adaptations**

A. Environmental Accessibility Adaptations are physical adaptations to the recipient's home or vehicle which are necessary to ensure his health, welfare and safety, or which enable him to function with greater independence in the home.

1. All adaptations to the home and vehicle must meet all applicable standards of manufacture, design and installation.

B. Environmental adaptation services to the home and vehicle include the following:

1. training the recipient and appropriate direct care staff in the use and maintenance of devices, controls, appliances and related items;

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

3. service contracts and other warranties.

C. Home accessibility adaptations may include the performance of assessments to determine the types of modifications that are needed and may include the following services to accommodate the medical equipment and supplies which are necessary to assure the welfare of the recipient:

1. installation of ramps and grab-bars;

2. widening of doorways;

3. modification of bathroom facilities; or

4. installation of specialized electric and plumbing systems.

D. Home accessibility adaptations may be applied to rental or leased property only with the written approval of the landlord and approval by OCDD.

E. When state and local building or housing code standards are applicable, modifications to the home shall meet such standards.

F. Service Exclusions for Home Adaptations

1. Home modification funds are not intended to cover basic construction cost. Waiver funds may only be used to pay the cost of purchasing specific approved adaptations for the home, not for the construction costs of additions to the home.

2. Home modifications shall not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

3. Home modifications shall not include those modifications which add to the total square footage of the home, except when the additional square footage is necessary to make the required adaptation work.

4. Home modifications shall not include those modifications which are of general utility and are not of direct medical or remedial benefit to the individual, including, but not limited to:

a. flooring;

b. roof repair;

c. central air conditioning;

d. hot tubs;

e. swimming pools;

f. exterior fencing; or

g. general home repair and maintenance.

G. Vehicle adaptations are modifications to an automobile or van that is the waiver recipient's primary means of transportation in order to accommodate his special needs. These adaptations must be specified in the ISP as necessary to enable the recipient to integrate more fully into the community and to ensure his health, welfare and safety.

1. The scope of vehicle modifications may include the performance of necessary assessments to determine the types of modifications that are necessary and may include the installation of a lift or other adaptations to make the vehicle accessible to the recipient or for the recipient to drive.

2. Maintenance and/or repair of vehicle adaptations are included for coverage under ROW.

H. Service Exclusions for Vehicle Adaptations

1. Payment will not be made to adapt vehicles that are owned or leased by paid caregivers or providers of waiver services, or to purchase or lease a vehicle.

2. Vehicle modifications which are of general utility and are not of direct medical or remedial benefit to the recipient are not covered in the ROW.

3. Regularly scheduled upkeep and maintenance of a vehicle is not covered.

4. Car seats are not considered a vehicle adaptation.

I. Provider Qualifications. In order to participate in the Medicaid Program, providers must meet the following qualifications.

1. Providers of environmental accessibility adaptations for the home must be registered through the Louisiana State Licensing Board for Contractors as a Home Improvement Contractor.

a. In addition, these providers must meet the applicable state and/or local requirements governing their licensure or certification.

b. The individuals performing the actual service (building contractors, plumbers, electricians, carpenters, etc.) must also comply with the applicable state and/or local requirements governing individual licensure or certification.

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.

a. Existing providers of environmental accessibility adaptations to vehicles must comply with the licensing and accreditation requirements within 12 months of the effective date of the final Rule.

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 for Citizens with Developmental Disabilities, LR 33:2446 (November 2007).

**§16313. Host Home**

A. Host Home services assist recipients in meeting their basic adaptive living needs and offer direct support where required. Recipients are afforded a welcoming, safe and nurturing family atmosphere in a family home environment. Host Home services are available to waiver recipients of any age and take into account compatibility, including individual interests, age, needs for privacy, supervision and support needs. These services are provided in a private home by a contractor of the host home agency who lives in the home, and either rents or owns the residence. The contractor utilizes specific teaching strategies to encourage independence and autonomy when required.

1. Host Home services may be provided by an individual unrelated to the recipient or by a family member, but shall not be provided by a parent, spouse or legally responsible relative or legal guardian.

B. Host Home services:

1. include assistance with the activities of daily living specified in the recipient's ISP;

2. assist recipients to develop their leisure interests and activities in the home setting and their relationships with other members in the household; and

3. provide other supports consistent with the recipient's goals, person-centered plans and identified support needs.

C. Host Home services are managed by provider organizations that are subject to licensure by the State. The provider organization is responsible for the following functions which are included in the reimbursement rate:

1. arranging for a host home and overseeing the delivery of services by the contractor and providing emergency services;

2. making an initial inspection of the host home, as well as periodic inspections, as required by licensing regulations; and

3. providing 24-hour oversight and supervision of Host Home services including back-up for the host home contractor for the scheduled and nonscheduled absences of the contractor;

a. The recipient, or his legally authorized representative if he is a minor, may agree for the recipient to temporarily move in with another host home family. In this instance, the host home provider is still responsible for oversight, supervision and back-up of the Host Home service.

D. Host Home contractors are responsible for:

1. assisting with the development of the recipient's ISP and must abide by the provisions of the plan;

2. maintaining and providing data to assist in the evaluation of the recipient's personal goals;

3. maintaining adequate records to substantiate service delivery and producing such records upon the Department's request;

4. undergoing any specialized training deemed necessary by the provider agency, or required by the Department, to provide supports in the Host Home setting;

5. immediately reporting to their agencies any major issues or concerns related to the recipient's safety and well-being;

6. assisting the recipient to access community services, activities and in pursuing and developing recreational and social interests outside the home;

7. facilitating the recipient in becoming a part of his community and assisting with the teaching of community living skills as outlined in the ISP to achieve the recipient's goals concerning his community and social life, as well as to maintain contacts with his biological family and natural supports as specified in the person-centered plans;

8. furnishing assistance to the recipient, who is either working or interested in working, and to the provider agency and other service entities in order to support the recipient's vocational objectives;

9. assisting recipients in keeping medical and therapy appointments, as well as attending these appointments when their support is beneficial; and

10. providing or arranging for transportation to school, work and medical/therapy appointments.

E. Host home contractors who serve children are required to provide daily supports and supervision on a 24-hour basis to meet on-going support needs and to handle emergencies as any family would do for their minor child as required and based on age, capabilities, health conditions and any special needs.

F. Host home contractors serving adults are required to be available for daily supervision, support needs or emergencies as outlined in the adult recipient's ISP based on medical, health and behavioral needs, age, capabilities and any special needs.

1. Host Home contractors that serve adults who have been interdicted must ensure that services are furnished in accordance with the legal requirements of the interdiction.

G. Host home contractors who are engaged in employment outside the home must adjust these duties to allow the flexibility needed to meet their responsibilities to the recipient.

H. Host Home Capacity. Regardless of the funding source, a host home contractor may not provide services for more than two recipients in the home.

I. Service Exclusions

1. Separate payment will not be made for Community Living Supports since these services are integral to, and inherent in, the provision of Host Home services.

2. Separate payment will not be made for the following residential service models if the recipient is receiving Host Home services:

a. Respite Care Services-Out of Home;

b. Shared Living;

c. Shared Living-Conversion; or

d. Companion Care.

3. The host home contractor may not be the same individual as the owner or administrator of the designated provider agency.

J. Provider Qualifications. Providers must be licensed as a Class A Child Placing Agency to serve children or be approved by OCDD to serve adults in the Host Home setting.

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 for Citizens with Developmental Disabilities, LR 33:2447 (November 2007).

**§16315. Intensive Community Supports**

A. Intensive Community Supports (ICS) are specialized behavioral and psychiatric supports for people in the community who are at imminent risk of institutionalization. ICS include a collaborative, inter-disciplinary approach to develop individualized behavioral and psychiatric strategies that are both person-centered and effective.

1. Intensive Community Supports are provided through a specialized professional treatment team consisting of a/an:

a. psychologist;

b. psychiatrist;

c. registered nurse;

d. social worker; and as needed,

e. an associate or assistant to a psychologist.

2. Each member is involved collaboratively in the development of an inter-disciplinary plan. The most clinically appropriate team member(s) represents the team in providing direct service to the recipient.

3. Critically appropriate team members must spend a minimum of one hour weekly meeting with the recipient and/or care givers at the onset of treatment.

4. Core team members include the:

a. psychologist;

b. social worker; and

c. registered nurse.

NOTE: Psychologists must provide clinical leadership and provide supports consistent with person-centered practices and Louisiana's Guideline for Behavioral Supports.

5. Core team members must review summary data at least weekly. Written behavioral support strategies must be reviewed and updated at least monthly, based on the recipient's response to services.

6. The team also works closely with support coordinators to assure a coordinated team effort when other professionals in the community are providing supports (e.g., a neurologist, primary care physician, or physical therapist).

B. Supports and services available through the ICS include:

1. psychological evaluations;

2. psychosocial assessments;

3. psychiatric evaluations;

4. medical screenings;

5. intensive formalized positive behavioral supports;

6. psychiatric treatments;

7. family and/or agency training;

8. service transition planning;

9. brief counseling therapies;

10. 24-hour on-call telephone supports; and

11. crisis planning.

C. Recipient Qualifications. Documentation is required to demonstrate that all of the following criteria for Intensive Community Supports services have been met. This documentation should especially demonstrate that existing services have not been able to remediate the participant's behavior and that more intensive interventions are necessary. To qualify for ICS, an individual must:

1. have an ongoing pattern of behavior that includes:

a. physical harm to self or others;

b. behaviors/psychiatric symptoms which have led to institutionalization in the past; or

c. psychiatric symptoms with a high probability of institutionalization including, but not limited to:

i. self-injurious behavior;

ii. physical aggression;

iii. illegal or inappropriate sexual acts;

iv. reckless endangerment;

v. psychiatric conditions leading to the denial of self-preservation; or

vi. extremely poor hygiene.

2. be at imminent risk of institutionalization;

3. have a need for 24-hour on-call telephone supports and crisis planning to support health and safety; and

4. have a rating of four or greater in Behavioral Supports on the Louisiana PLUS.

D. Service Exclusions

1. Intensive Community Supports do not include onsite crisis intervention services and cannot adequately serve people who:

a. threaten or attempt suicide or homicide; or

b. have a pattern of felony violations involving violence or the victimization of others.

2. When the ICS team is officially invoked for intensive or specialized situations, service authorization will not be approved and reimbursement will not be paid for other behavioral consultants/professional service providers who are not members of the ICS Team. The team may bill a team rate under the ICS definition provided their new service plan has been written and their assessment conducted.

3. Individual ICS Team members can subsequently bill an individual rate under the Professional Services definition for their follow-up services related to the ICS Team's assessment and service plan, provided this service is clearly linked to their ICS Team responsibilities.

4. Individual ICS Team members may also bill an individual rate under the Professional Services definition for services not linked to their ICS Team responsibilities, provided these services are clearly differentiated as regular, non-ICS professional services.

E. Provider Qualifications

1. Providers of ICS must have a current, valid license as a Family Support Agency serving individuals with developmental disabilities.

F. Staffing Qualifications

1. ICS Team members must possess a current, valid license issued by the appropriate governing board of Louisiana for that profession. The specific service delivered must be consistent with the scope of the license held by the professional.

a. Each ICS Team member must have a minimum of two years experience providing professional services to people with developmental disabilities or receive supervision by professional staff that has the requisite experience.

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 for Citizens with Developmental Disabilities, LR 33:2448 (November 2007).

**§16317. Nursing Services**

A. Nursing services are medically necessary services ordered by a physician and provided by a licensed registered

nurse or a licensed practical nurse within the scope of the State's Nurse Practice Act. The services require an individual nursing service plan and must be included in the Individual Support Plan.

1. Nursing services provided in the ROW are an extension of nursing services provided through the Home Health Program under the Medicaid State Plan.

2. A physician's letter of medical necessity, 90-L and 485, an individual nursing service plan, a summary of medical history and the nursing checklist are required for nursing services.

3. The nurse must submit updates of any changes to the individual's needs and/or the physician's orders to the support coordinator every 60 days.

B. Nursing consulting services include assessments and health related training and education for recipients and caregivers.

1. Assessment services are offered on an individual basis only and must be performed by a registered nurse.

2. Consulting services may also address healthcare needs related to prevention and primary care activities.

3. The health related training and education service is the only nursing service which can be provided to more than one recipient simultaneously. In this instance, each recipient is billed for his or her portion of the total service time.

C. Service Requirement. Recipients must first exhaust all available nursing visits provided under the Medicaid State Plan prior to receiving services through the waiver program.

D. Provider Qualifications

1. In order to participate in the Medicaid Program, the provider agency must possess a current, valid license as a home health agency or be an enrolled Shared Living Services agency with a current, valid license as a Supervised Independent Living agency.

E. Staffing Requirements

1. Nursing services shall be provided by individuals with either a current, valid license as a registered nurse from the Louisiana State Board of Nursing or a current, valid license as a practical nurse from the Board of Practical Nurse Examiners.

2. The RN or the LPN must possess two years of service delivery experience to persons with developmental disabilities post licensure.

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 for Citizens with Developmental Disabilities, LR 33:2449 (November 2007).

**§16319. One Time Transitional Services**

A. One Time Transitional Services are one-time, set-up services to assist individuals in making the transition from an ICF/MR to their own home or apartment in the community of their choice.

1. Allowable transitional expenses may include:

a. nonrefundable security deposits that do not include rental payments;

b. set up fees for utilities;

c. essential furnishings to establish basic living arrangements, including:

i. bedroom and living room furniture;

ii. table and chairs;

iii. window blinds

iv. food preparation items and eating utensils; and

v. a telephone; and

vi. moving expenses to occupy a community domicile;

d. health and safety assurances including,:

i. pest eradication;

ii. allergen control; or

iii. one-time cleaning prior to occupancy.

B. The recipient's support coordinator will arrange for transitional services for the individual.

C. Service Limits

1. Set-up transitional expenses are capped at $3,000 per person over a recipient's lifetime.

D. Service Exclusions

1. Payment shall not be made for housing, rent or refundable security deposits.

2. One time transitional services are not available to waiver recipients who are receiving Host Home services.

3. One time transitional services are not available to waiver recipients who are moving into a family member's home.

E. The Office for Citizens with Developmental Disabilities shall be the entity responsible for coordinating the delivery of one time transitional services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2449 (November 2007).

**§16321. Personal Emergency Response System (PERS)**

A. Personal Emergency Response System (PERS) is an electronic device which enables individuals to secure help in an emergency. The individual may also wear a portable help button to allow for mobility. The system is connected to the person's telephone and programmed to signal a response center once a help button is activated.

B. Recipient Qualifications. PERS services are available to individuals who:

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

2. are unable to use other communication systems because they are inadequate to summon emergency assistance; or

3. do not have 24-hour direct supervision.

C. Coverage of the PERS includes the rental of the electronic device, the initial installation, training the recipient to use the equipment, and monthly maintenance fees.

D. Service Exclusions

1. Separate payment will not be made for Shared Living Services when PERS services are utilized since 24-hour direct supervision is available.

E. Provider Qualifications. The provider must be authorized by the manufacturer to install and maintain equipment for personal emergency response systems. The provider shall be in compliance with all applicable federal, state, and local regulations governing the operation of personal emergency response systems including staffing requirements for the response center.

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 for Citizens with Developmental Disabilities, LR 33:2249 (November 2007).

**§16323. Prevocational Services**

A. Prevocational Services are pre-vocational activities designed to assist individuals in acquiring and maintaining basic work-related skills for competitive employment. Because of their disabilities, these individuals need intensive ongoing support to perform in a paid work setting. Services should be offered to engage individuals in real and simulated employment tasks to determine their vocational potential. Overall goals of the program include regular community inclusion and development of work skills and habits to improve the employability of the individual. These services must be reflective of the recipient's ISP and directed toward habilitation rather than teaching a specific job skill.

1. Prevocational Services should focus on teaching concepts and skills such as:

a. following directions;

b. attending to task;

c. task completion;

d. problem solving; and

e. job safety skills.

2. The primary focus of Prevocational Services is the acquisition of employment related skills based on the individual's vocational preferences and goals.

a. These activities should include formal strategies for teaching the skills and the intended outcome for the individual.

b. Individualized progress for the activities should be routinely reviewed and evaluated with revisions made as necessary.

B. In the event recipients are compensated in the employment-related training services, the compensation must be in accordance with the United States Fair Labor Standards Act of 1985.

1. If recipients are paid in excess of 50 percent of the minimum wage, the provider must, at a minimum:

a. conduct 6-month formal reviews to determine the suitability of this service rather than Supported Employment services;

b. make recommendations to transition the individual to a more appropriate vocational opportunity; and

c. provide the support coordinator with documentation of both the productivity time studies and documented reviews of current placement feasibility.

C. Service Limits

1. Services shall be furnished on a regularly scheduled basis for no more than 8 hours a day, 5 days a week.

a. services may be furnished either half-day (over 2 and up to 4 hours per day) or full-day (over 4 hours per day) based on time spent on-site by the recipient.

D. Service Exclusions

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

2. Claims may be submitted for only one vocational or habilitative service per day.

3. Prevocational Services cannot be provided or billed for the same time as the following services:

a. Community Living Supports;

b. Professional Services except direct contacts needed to develop a behavioral management plan; or

c. Respite Care Services–Out of Home.

4. The provider is responsible for all transportation related to provision of the service, but is not responsible for transportation to and from the recipient's home.

5. Time spent in traveling to and from the prevocational program site shall not be included in the calculation of the total number of service hours provided per day.

a. Travel training for the purpose of teaching the recipient how to use transportation services may be included in determining the total service numbers hours provided per

day, but only for the period of time specified in the recipient's ISP.

E. Provider Qualifications. Providers must have a current, valid license as an Adult Day Care Center or have a Compliance Certificate from Louisiana Rehabilitation Services as a Community Rehabilitation Program.

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 for Citizens with Developmental Disabilities, LR 33:2450 (November 2007).

**§16325. Professional Services**

A. Professional Services are direct services to recipients, based on need, that are designed to increase the individual's independence, participation and productivity in the home, work and community. Professional services must be delivered with the recipient present and be provided based on the approved ISP and an individualized service plan. Service intensity, frequency and duration will be determined by individual need. Professional services may be utilized to:

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

2. perform assessments and/or re-assessments and provide recommendations;

3. intervene in and stabilize a crisis situation (behavioral or medical) that could result in the loss of home and community-based services, including the development, implementation, monitoring, and modification of behavioral support plans;

4. provide consultative services and recommendations;

5. provide necessary information to the individual, family, caregivers, and/or team to assist in planning and implementing plans per the approved ISP;

6. provide caregiver training that includes instructions in skills and knowledge pertaining to the support and assistance of persons with developmental disabilities and is intended to allow caregivers to become more proficient in meeting the needs of eligible individuals;

a. All caregiver training must be included in the recipient's ISP.

7. provide caregiver counseling for the natural, adoptive, foster, or host family members of individuals with disabilities, to develop and maintain healthy, stable relationships among all caregivers, including family members, to meet the needs of the recipient; and

a. Emphasis is placed on the acquisition of coping skills by building upon family strengths. Services are intended to maximize the emotional and social adjustment and well-being of the individual, family, and caregiver.

8. provide nutritional services, including dietary evaluation and consultation with individuals or their care provider.

a. Services are intended to maximize the individual's nutritional health.

B. Professional services covered in the ROW include:

1. occupational therapy;

2. physical therapy;

3. speech therapy;

4. dietary and nutritional services;

5. social work services; and

6. psychological services.

C. Service Exclusions

1. Professional services related to behavioral health services will not be authorized once the Intensive Community Supports team is officially invoked for intensive or specialized situations.

a. Individual ICS Team members may subsequently submit a claim under the Professional Services for their follow-up services related to the ICS Team's assessment and service plan provided this service is clearly linked to their ICS Team responsibilities.

b. Individual ICS Team members may also submit a claim under the Professional Services for services that are not linked to their ICS Team responsibilities provided these services are clearly differentiated as regular, non-ICS professional services.

2. Professional services may only be furnished and reimbursed through ROW when the services are not covered under the Medicaid State Plan as medically necessary, but are of habilitative or remedial benefit to the recipient.

3. Recipients who are participating in ROW and are up to the age of 21 must access these services through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

a. Recipients who are over the age of 21 must exhaust the professional services available under the Medicaid State Plan before accessing these services through ROW.

D. Provider Qualifications.

1. Individual practitioners who enroll as providers of Professional Services must have a current, valid license from the appropriate governing board of Louisiana for that profession.

a. In addition, the professional must possess two years of service delivery experience with persons with developmental disabilities or receive supervision by professional staff that has the requisite experience.

2. Provider agencies must have Medicare certification as a Free-Standing Rehabilitation Center or a current, valid license as a:

a. Home Health agency,

b. Personal Care Attendant agency,

c. Supervised Independent Living agency; or

d. Family Support Agency serving people with developmental disabilities.

E. Staffing Requirements. Individuals furnishing professional services may either be employed by or have a contract with the enrolled provider agency.

1. Professional services must be provided by individuals with a current, valid license from the appropriate governing board of Louisiana for that profession. The specific service delivered must be consistent with the scope of the license held by the professional.

2. Each professional must also possess two years of service delivery experience with persons with developmental disabilities or receive supervision by professional staff that has the requisite experience.

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 for Citizens with Developmental Disabilities, LR 33:2450 (November 2007).

**§16327. Respite Care Services–Out of Home**

A. Respite Care Services–Out of Home are supports and services provided for the relief of those unpaid caregivers who normally provide care to recipients who are unable to care for themselves. These services are furnished on a short-term basis in a respite center by a licensed respite provider. Respite Care services are necessary to prevent individuals from being institutionalized.

1. A licensed respite care facility shall insure that community activities are available to the recipient in accordance with his approved ISP, including transportation to and from these activities.

a. The rate for Respite Care Services–Out of Home includes the transportation costs for the community activities.

2. While receiving respite care services, the recipient's routine is maintained in order to attend school, school activities, work or other community activities he would receive if he was not in the center-based respite facility.

B. Service Limits

1. Respite Care Services are limited to 720 hours per recipient, per Individual Support Plan year. Requests for an extension of the service limit are subject to the Department's established approval process and require proper justification and documentation.

C. Service Exclusions

1. Room and board shall be covered only if it is provided as part of respite care furnished in a state-approved facility that is not a private residence.

2. Respite Care Services-Out of Home may not be billed for recipients receiving the following services:

a. Shared Living;

b. Shared Living Conversion;

c. Companion Care; or

d. Host Home.

D. Provider Qualifications. The provider must possess a current, valid license as a Respite Care Center.

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 for Citizens with Developmental Disabilities, LR 33:2451 (November 2007).

**§16329. Shared Living Services**

A. Shared Living Services assist the recipient in acquiring, retaining and improving the self-care, adaptive and leisure skills needed to reside successfully in a shared home setting within the community. Services are chosen by the recipient and developed in accordance with his goals and wishes for his particular shared living setting with regard to compatibility, interests, age and privacy.

1. A Shared Living Services provider delivers supports which include 24-hour staff presence and responsibilities as required in each recipient's ISP.

2. The provider is responsible for the daily schedule to provide the support, supervision, safety and security pertinent to the individual as he engages in a variety of community work and recreational/leisure activities and associations.

3. This service includes assistance with all of the activities of daily living.

B. Shared Living Conversion Option. The Shared Living Conversion Option is allowed only in homes which were previously licensed and certified as an ICF/MR for up to a maximum of eight licensed and Medicaid-funded beds on June 30, 2007.

1. The number of individuals residing in this service model shall not exceed the licensed and Medicaid-funded bed capacity of the ICF/MR on June 30, 2007 or up to six individuals, whichever is less.

C. Shared Living Option

1. A Shared Living Option is allowed for new or existing providers for up to a maximum of three individuals in a shared home setting. These shared home settings must be either a home owned or leased by the waiver recipients, or a home owned or leased and operated by a licensed shared living provider.

2. A Shared Living Option for up to a maximum of four individuals in a shared home setting is limited to

existing licensed and certified public or private ICFs/MR which elect to downsize into this model.

D. Service Exclusions

1. Payments are not made for room and board, the cost of home maintenance, upkeep or improvements.

2. Separate payment will not be made for transportation for the purpose of community access as this is a component of Shared Living services.

3. The following services are not available to recipients utilizing Share Living and Shared Living Conversion Services:

a. Community Living Supports;

b. Respite Care Services;

c. Companion Care; or

d. Host Home.

E. Provider Qualifications. Providers must be enrolled as a Shared Living agency and have a current, valid license as a Supervised Independent Living 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 for Citizens with Developmental Disabilities, LR 33:2452 (November 2007).

**§16331. Specialized Medical Equipment and Supplies**

A. Specialized Medical Equipment and Supplies includes durable and non-durable equipment that is necessary to address the functional limitations of the recipient as well as items necessary to support life or to address physical conditions, along with the ancillary supplies and equipment needed for proper functioning of such items. Specialized medical equipment and supplies may only be furnished and reimbursed through ROW when the services are not covered under the Medicaid State Plan as medically necessary, but are of habilitative or remedial benefit to the recipient.

1. Coverage includes for the purchase and/or rental of equipment, devices, controls, appliances and supplies specified in the ISP which increases the recipient's ability to:

a. perform activities of daily living;

b. perceive, control or communicate with his environment; or

c. maintain health and safety.

B. Items provided through this waiver are in addition to any medical equipment and supplies covered under the Medicaid State Plan. All items must meet applicable standards of manufacture, design and installation.

C. Services include the following:

1. training the recipient and caregivers in the use and maintenance of equipment, devices, controls, appliances, supplies and related items;

2. repair and upkeep of all equipment, including battery purchases and other reoccurring replacement items that contribute to ongoing maintenance of the equipment; and

3. service contracts and other warranties.

D. Equipment includes the following items that are not covered under the Medicaid State Plan, Medicare and/or other funding sources:

1. specialized mobility devices (excluding wheelchairs);

2. specialized positioning devices or equipment;

3. therapeutic shoe inserts;

4. specialized medical equipment such as electronic lifts;

5. adaptive devices and equipment prescribed by a therapist for exercise;

6. alternative and augmentative communication boards, electronic communication devices and interfaces to operate prescribed devices.

E. Service Exclusions

1. Any equipment, device, appliance or supply that is covered under the Medicaid State Plan, Medicare or any other third party insurance is excluded from coverage in the ROW.

2. Specialized equipment and supplies that are of general utility or maintenance and are not of direct medical or remedial benefit to the individual are excluded from coverage in the ROW.

F. Provider Requirements. In order to enroll to participate in the Medicaid Program, vendors of specialized medical equipment and supplies must furnish written documentation of authorization to sell, install and/or repair specialized equipment and supplies from the respective manufacturer of the designated 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 for Citizens with Developmental Disabilities, LR 33:2452 (November 2007).

**§16333. Support Coordination**

A. Support Coordination services are provided to all ROW recipients to assist them in gaining access to all of their needed services regardless of the funding source for the services. Support Coordination will provide information and assistance to waiver recipients in directing and managing their services in compliance with the rules and regulations governing case management services.

1. Support Coordinators shall be responsible for ongoing monitoring of the provision of services included in the recipient's approved ISP.

2. Support coordinators shall also participate in the Evaluation and Re-evaluation of the recipient's ISP.

B. Support coordinators are responsible for providing assistance to recipients who choose the self-direction option with their review of the Self-Direction Employer Handbook and for being available to these recipients for on-going support and help with carrying out their employer responsibilities.

C. Provider Qualifications. Providers must have a current, valid license as a case management agency and meet all other requirements as set forth in LAC 50:XV.Chapter 105.

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 for Citizens with Developmental Disabilities, LR 33:2453 (November 2007).

**§16335. Supported Employment**

A. Supported Employment is competitive work in an integrated work setting, or employment in an integrated work setting, in which the individuals are working toward competitive work.

1. The support services provided are consistent with the individual's:

a. strengths;

b. resources;

c. priorities;

d. concerns;

e. abilities;

f. capabilities;

g. interests; and

h. informed choices.

2. Ongoing support services are provided to individuals for whom competitive employment has not traditionally occurred.

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

B. Supported Employment services include:

1. individual placement which is a supported employment 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 worksite;

2. services that assist a recipient to develop and operate a micro-enterprise;

a. This service consists of:

i. assisting the recipient to identify potential business opportunities;

ii. assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business;

iii. identification of the supports that are necessary in order for the recipient to operate the business; and

iv. ongoing assistance, counseling and guidance once the business has been launched.

3. enclave services which is an employment situation in competitive employment in which a group of eight or fewer workers with disabilities are working at a particular work setting. The disabled workers may be disbursed throughout the company and among non-disabled workers or congregated as a group in one part of the business; and

4. mobile work crews which is a group of eight or fewer workers with disabilities who perform work in a variety of locations under the supervision of a permanent employment specialist (job coach/supervisor).

C. Service Limits

1. The required minimum number of service hours per day for Supported Employment is as follows for:

a. individual placement services, the minimum is one hour;

b. services that assist a recipient to develop and operate a micro-enterprise, the minimum is one hour;

c. an enclave, the minimum is five hours; and

d. a mobile work crew, the minimum is five hours.

D. Service Exclusions

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

2. Billing may be made for only one vocation or habilitative service per day.

3. Supported Employment Services cannot be billed for the same time as any of the following services:

a. Community Living Supports;

b. Professional Services except direct contacts needed to develop a behavioral management plan; or

c. Respite Care Services–Out of Home.

4. The provider is responsible for all transportation related to provision of the service, but is not responsible for transportation to and from the recipient's home.

5. Time spent in traveling to and from the prevocational program site shall not be included in the calculation of the total number of service hours provided per day.

a. Travel training for the purpose of teaching the recipient how to use transportation services may be included

in determining the total service numbers hours provided per day, but only for the period of time specified in the recipient's ISP.

6. The following incentive payments, subsidies or unrelated vocational training expenses are excluded from coverage in Supported Employment services:

a. incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

b. payments that are passed through to users of supported employment programs; or

c. payments for vocational training that is not directly related to an individual's supported employment program.

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

E. Provider Qualifications. Providers must have a Compliance Certificate from Louisiana Rehabilitation Services as a Community Rehabilitation Program.

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 for Citizens with Developmental Disabilities, LR 33:2453 (November 2007).

**§16337. Transportation Services**

A. Transportation services enable waiver recipients to gain access to waiver and other community services, activities and resources. These services are necessary to increase independence, productivity, and community inclusion as outlined in the recipient's ISP. Transportation services under the waiver shall be offered in accordance with the recipient's ISP and must be documented in the ISP.

1. The recipient must be present to receive this service.

2. Whenever possible, the recipient must utilize the following resources for transportation:

a. family, neighbors, friends or community agencies which can provide this service without charge; or

b. public transportation or the most cost-effective method of transport available.

B. Transportation for community access and for habilitative and vocational services represents two separate and distinct services.

1. Transportation-Community Access is intended to assist the recipient to access community activities, resources and services to increase integration with persons who do not have developmental disabilities.

2. Transportation-habilitative and vocational is intended to assist the recipient to access Day Habilitation, Pre-Vocational and Supported Employment services.

a. These services are meant to provide maximum flexibility to the recipient to choose the mode of transportation that he wishes to use to reach a habilitative or vocational site. Therefore, transportation for this purpose is available and billable only if the individual receives a vocational or habilitative service on the day that this service is provided.

C. Service Limits

1. All community access trips shall be identified in the recipient's ISP. These trips are limited to three per day and must be arranged for geographic efficiency. Greater than three trips per day require approval from the Department of Health and Hospitals or its designee.

2. This service is limited to a maximum of two one-way trips per service day for a maximum of 264 days, 528 service units per year.

D. Service Exclusions

1. Transportation services offered through ROW shall not replace the medical transportation services covered under the Medicaid State Plan or transportation services provided as a means to get to and from school.

2. Separate payment will not be made for transportation-community access and the following services:

a. Shared Living Services; or

b. Respite Care Services–Out of Home.

E. Provider Qualifications. In order to participate in the Medicaid Program, transportation providers must comply with the following requirements. Providers of other waiver services (Day Habilitation, Supported Employment, Shared Living, etc.) may also separately enroll as transportation providers and must comply with the same requirements.

1. Transportation providers must comply with all state laws and local ordinances governing vehicle licensing, registration, inspection and operation.

2. For profit providers shall have a minimum liability insurance coverage of $100,000 per person and $300,000 per accident or a $300,000 combined service limits policy.

a. The liability policy shall cover all automobiles owned or leased by the provider utilized for furnishing transportation services.

b. Premiums shall be prepaid for a period of six months. Verification of prepaid insurance must be a true and correct copy of the policy issued by home office of the insurance company. The verification must include the dates of coverage and a 30 day cancellation notification clause.

i. Statements from the agent writing the policy will not be acceptable.

c. Verification of renewal of the insurance policy must be submitted to the Bureau of Health Services

Financing (BHSF) no later than 48 hours prior to the end date of coverage.

i. The policy must provide that the 30 day cancellation notification be issued to BHSF. Upon receipt of the cancellation or expiration of coverage notice, the provider agreement for participation will be immediately cancelled. The ending date of participation shall be the ending date of insurance coverage.

ii. Retroactive coverage statements will not be accepted.

d. Providers who lose the right to participate in the Medicaid Program due to lack of prepaid insurance may re-enroll and will be subject to all applicable enrollment procedures, policies, and fees for new providers.

3. In order to receive reimbursement for transporting Medicaid recipients to waiver services, family and friends must maintain the state minimum automobile liability insurance coverage, a current state inspection sticker, and a current valid driver's license.

a. No special inspection by the Medicaid agency will be conducted.

b. Documentation of compliance with the three listed requirements for this class of provider must be submitted when enrollment in the Medicaid agency is sought. Acceptable documentation shall be the sworn and notarized statement of the individual enrolling for payment that all three requirements are met.

c. Family and friends transportation providers are limited to transporting up to three specific waiver recipients.

F. Staffing Requirements. All drivers employed by for profit and non-profit transportation services providers must have a current, valid class D (chauffeur) license.

G. Vehicle Requirements. All vehicles utilized by for profit and non-profit transportation services providers for transporting waiver recipients must comply with all applicable state laws and regulations and are subject to inspection by the Department of Health and Hospitals or its designee.

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 for Citizens with Developmental Disabilities, LR 33:2454 (November 2007).

# Chapter 165. Self-Direction Initiative

### §16501. Self-Direction Service Option

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

B. Recipient Responsibilities. Waiver recipients choosing the self-direction service option must understand the rights, risks and responsibilities of managing their own care and individual budget. If the recipient is unable to make decisions independently, he must have an authorized representative who understands the rights, risks and responsibilities of managing his care and supports within his individual budget. Responsibilities of the recipient or authorized representative include:

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

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

a. Recipients must adhere to the health and welfare safeguards identified by the team, including:

i. the application of a comprehensive monitoring strategy and risk assessment and management systems; and

ii. compliance with the requirement that employees under this option must have criminal background checks prior to working with waiver recipients;

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 recipient's ISP to meet his needs.

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

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

1. Voluntary termination. The waiver recipient may choose at any time to withdraw from the self-direction service option and return to the traditional provider agency management of services.

2. Involuntary termination. The Department may terminate the self-direction service option for a recipient and require him to receive provider-managed services under the following circumstances:

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

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

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

d. over three payment cycles in the period of a year, the recipient 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 and the ISP;

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. Employees of recipients in the self-direction service option are not employees of the fiscal agent or the Department of Health and Hospitals.

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 for Citizens with Developmental Disabilities, LR 33:2455 (November 2007).

# Chapter 167. Provider Participation

### §16701. General Provisions

A. In order to participate in the Medicaid Program as a provider of services in the Residential Options Waiver, a provider must:

1. meet all of the requirements for licensure and the standards for participation in the Medicaid Program as a home and community-based services provider in accordance with state laws and the rules promulgated by the Department; and

2. comply with the regulations and requirements specified in LAC 50:XXI, Subparts 1 and 13 and the ROW provider manual.

B. Providers must maintain adequate documentation to support service delivery and compliance with the approved ISP and provide said documentation upon the Department's request.

C. In order for a provider to bill for services, the waiver recipient and the direct service worker or professional services practitioner rendering service must be present at the time the service is rendered.

1. Exception. The following services may be provided when the recipient is not present:

a. environmental accessibility adaptations;

b. personal emergency response systems; and

c. one-time transitional services.

2. All services must be documented in service notes which describe the services rendered and progress towards the recipient's personal outcomes and his ISP.

D. If transportation is provided as part of a waiver service, the provider must comply with the requirements for transportation services providers set forth in §16337.G.- I.

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 for Citizens with Developmental Disabilities, LR 33:2455 (November 2007).

# Chapter 169. Reimbursement

### §16901. Reimbursement Methodology

A. Reimbursement for the following services shall be a prospective flat rate for each approved unit of service provided to the waiver recipient. One quarter hour (15 minutes) is the standard unit of service, which covers both the service provision and administrative costs for these services:

1. respite care;

2. community living supports (CLS):

a. up to three recipients may share CLS services if they share a common provider of this service;

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

3. professional services furnished by a/an:

a. psychologist;

b. speech therapist;

c. physical therapist;

d. occupational therapist;

e. social worker; or

f. dietician/nutritionist;

4. nursing services;

5. intensive community supports; and

6. supported employment.

B. The following services are reimbursed at the cost of adaptation device, equipment or supply item:

1. environmental accessibility adaptations;

a. upon completion of the environmental accessibility adaptations and prior to submission of a claim for reimbursement, the provider shall give the recipient a certificate of warranty for all labor and installation work and supply the recipient with all manufacturers' warranty certificates.

2. assistive technology; and

3. specialized medical equipment and supplies.

C. The following services are reimbursed at a per diem rate:

1. host home;

2. companion care living services;

3. shared living services;

a. per diem rates are established based on the number of individuals sharing the living service module for both for shared living and shared living conversion services.

D. The following services are reimbursed at a per diem rate which may be billed either half-day (over 2 and up to 4 hours per day) or full-day (over 4 hours per day) based on time spent on-site by the recipient:

1. day habilitation; and

2. pre-vocational.

E. The reimbursement for transportation services is a flat fee based on a capitated rate.

F. Support coordination services shall be reimbursed at a fixed monthly rate in accordance with the terms of the established contract.

G. Installation of a personal emergency response system (PERS) is reimbursed at a one-time fixed rate and maintenance of the PERS is reimbursed at a monthly rate.

H. Transition expenses from an ICF/MR or nursing facility to a community living setting are reimbursed at the cost of the service(s) up to a one-time maximum rate.

I. Dental services are reimbursed at the Medicaid fee-for-service rate.

J. Reimbursement Exclusion. No payment will be made for room and board under this waiver program.

K. Reserved.

L. Effective for dates of service on or after July 1, 2012, the reimbursement for residential options waiver services shall be reduced by 1.5 percent of the rates in effect on June 30, 2012.

1. The following services shall be excluded from this rate reduction:

a. personal emergency response services;

b. environmental accessibility adaption services;

c. specialized medical equipment and supplies; and

d. transitional services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2456 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:1049 (April 2013).

**§16903. Direct Support Staff Wages**

A. In order to maximize staffing stability and minimize turnover among direct support staff, providers of the following services furnished under the Residential Options Waiver are required to pay direct support workers an hourly wage that is at least 29 percent ($1.50) more than the federal minimum wage in effect as of July 23, 2007 or the current federal minimum wage, whichever is higher.

1. Community Living Supports;

2. Respite Services-Out of Home;

3. Shared Living Conversion Option;

4. Shared Living Option;

5. Day Habilitation;

6. Prevocational Services; and

7. Supported Employment.

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 for Citizens with Developmental Disabilities, LR 33:2456 (November 2007).